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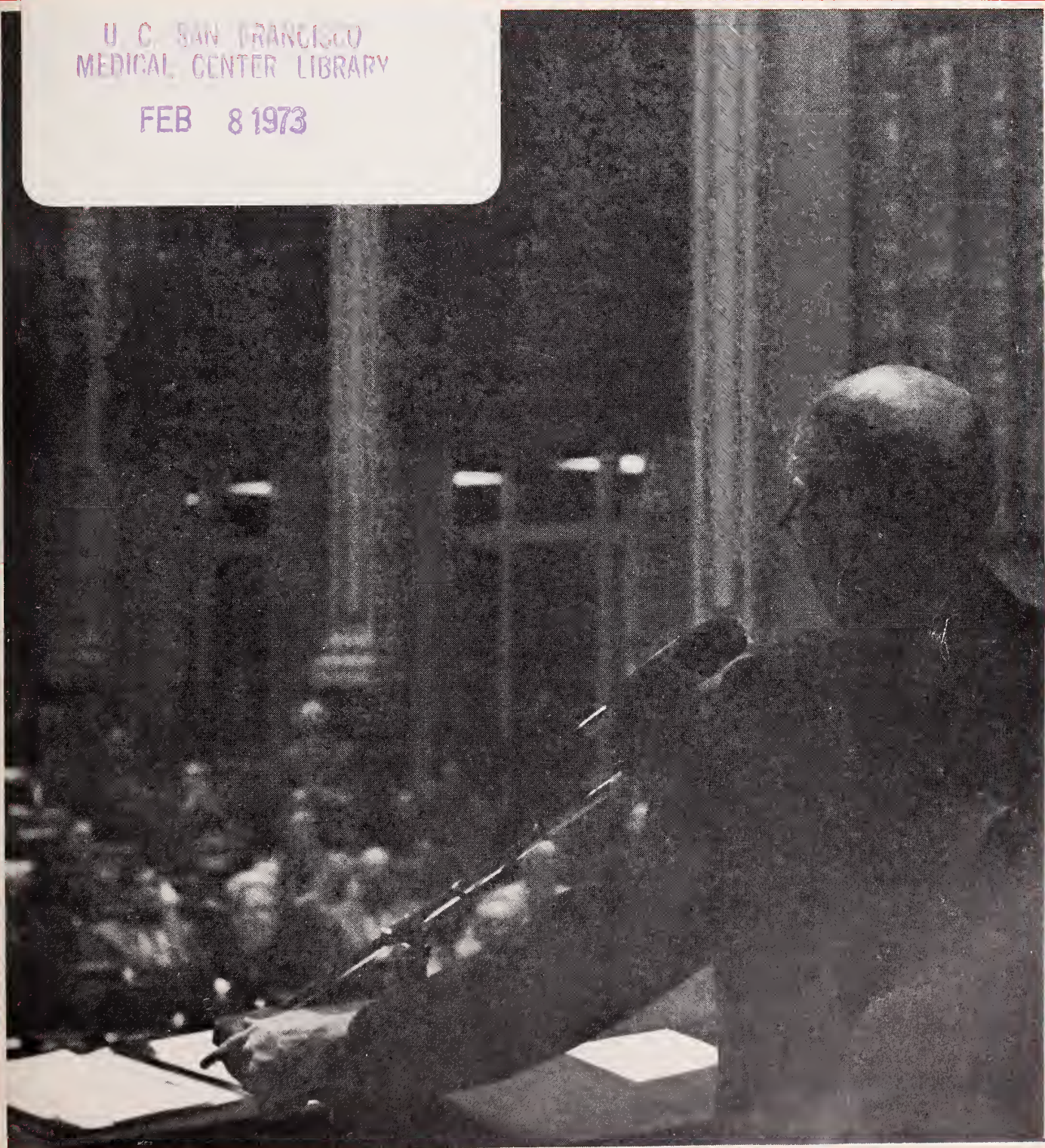
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Frustration and abandonment are not justified until all efforts at vaginal closure have been expended.

The Complicated Vaginal Fistula

RICHARD C. BORONOW, M.D.,* *Jackson, Mississippi*

IF ONE GOES BACK in medical history a century or so, all vaginal fistulas were "complicated" vaginal fistulas. Certainly most aspects of major progress in what we call "modern surgery" today evolved in the past three decades. Specifically the monumental achievements in blood banking, the development of antibiotics and the sophistication of anesthesia all have made significant contributions to every aspect of contemporary surgery.

But major milestones in vaginal fistula surgery do date back into the mid-1800's. In 1839, George Haywood, at the Massachusetts General Hospital, emphasized the separation of the vagina from the bladder in conducting the repair. In 1852, Marion Sims introduced silver wire as a suture material that subsequently gained wide favor. In 1894, Mackenrodt stressed mobilization of all layers prior to closure. In 1896, Kelly closed some huge defects and emphasized wide mobilization of layers, and also introduced the concept of ureteral catheterization as a technical aid. In 1914, Latzko, describing the partial colpocleisis procedure, combined the concepts of adequate mobilization and separation of layers, and good healthy tissue. Thus early in the 20th century sound basic surgical principles had been defined.

The variety of locations of vaginal fistulas are well known to any gynecologist with any experience. The particular fistulas that we will discuss today are rectovaginal and vesicovaginal.

There has been an interesting shift in the frequency of etiologic factors in the vaginal fistula. Early in the 20th century the obstetrical fistula—the unfortunate result of patient negligence or imprecise management of the second stage—was the rule. Other causes include gynecologic surgery, cervix cancer, radiation therapy, and congenital. At this point in time the relative frequency of the obstetrical fistula has markedly dropped and fistulas secondary to gynecologic surgery and to radiation therapy, usually for cervix cancer, are the major causes. This is a result of mid-20th century obstetrical care although in the rural recesses of our states we are sometimes shocked by the occasional obstetrical nightmare.

Important however is the recognition, that today, all vaginal fistulas are not "complicated" vaginal fistulas. The majority can be repaired by a variety of conventional standard techniques. But some fistulas do justify the designation of "complicated" by virtue of: (1) size, (2) location, (3) coincidental tissue injury. The very large fistula is obviously a technical problem because of the necessity of extensive mobilization of tissues. The fistula high in the vagina may be technically inaccessible particularly if there is any fixation of the vault, narrowing of the vault or associated tissue injury. The third factor is often one of primary concern: the concomitant tissue injury seen most characteristically with the radiation injury produces a most unfavorable setting for fistula closure. Examples of complicated vaginal fistulas are shown in Figure 1 and Figure 2.

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Favorite Techniques

Every surgeon has pet techniques and recommendations. If his results are good he is most likely to trust firmly in his approach. The techniques recorded in this presentation are based on the author's experience and we feel that they have been useful in our management of some of these very difficult fistulas. (Table 1).

TABLE 1 DESCRIPTION OF RADIATION INDUCED FISTULAS		
	No.	Average Size of Defect Centimeters
Rectovaginal	17	4
Vesicourethrovaginal	2	6
Vesicovaginal	2	4

While our discussion now will focus on the prob-

lem of the radiation induced vaginal fistula, many of the principles are, I believe, usefully applicable to any fistula complicated by associated tissue injury or complicated by virtue of great size. The case illustrated in Figure 2 was successfully closed by following these principles but was unassociated with radiation or adjacent tissue injury.

The initial step is to exclude persistent or recurrent cancer. A complete metastatic survey is indicated. Examination under anesthesia with liberal biopsies should be carried out to exclude reactive cancer. Certain ominous systemic complaints such as weight loss, which initially suggests active cancer, are quite frequently found in association with profound radiation injury.

Secondly one must await completion of the radiation effect. The acute necrosis is quite profound and one must not proceed with any attempted closure until the fistula "matures" and this is apparent clinically with the passage of time. We have never attempted a closure in less than six months after the injury and often, a longer delay is necessary.

Thirdly the fecal stream must be diverted with the



FIGURE 1

This radiation-induced urethrovesicovaginal fistula involved the entire bladder base. The ureteral catheter is seen at the meatus of the 1 centimeter residual urethra (one arrow), coursing the open bladder and entering the right ureteral orifice (two arrows), at the fistula margin. This defect was successfully closed with the first operation. From the Boronow article in *Am. J. Obstet-Gynec.*

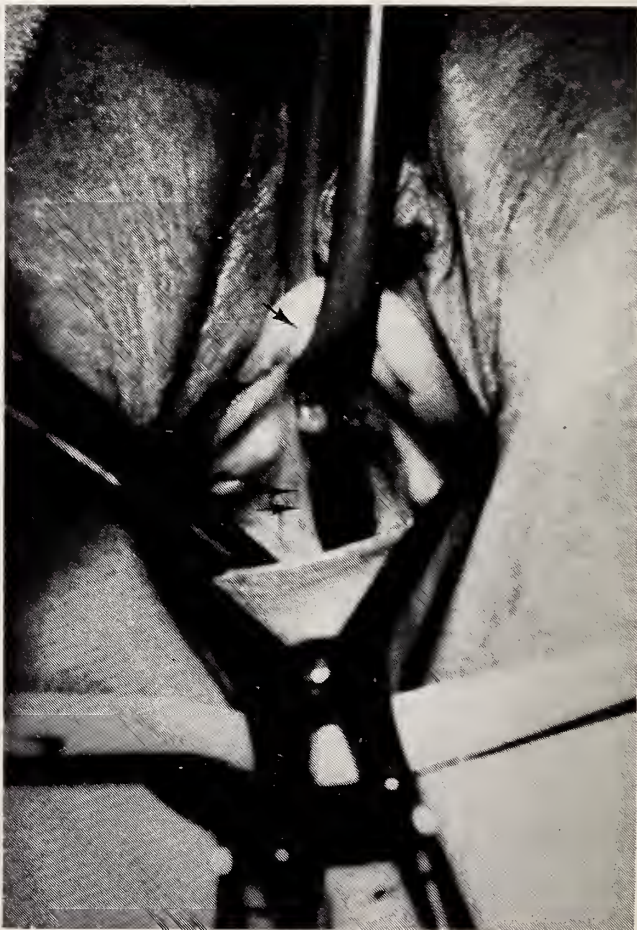


FIGURE 2

This urethrovesicovaginal fistula followed a series of transvaginal drainages of pelvic abscesses and several fistula closure attempts. There is complete urethral loss except the distal 1 centimeter (one arrow with urethral catheter looped through). The bladder neck was also lost (two arrows). This defect was successfully reconstructed and closed with the first operation.

rectal fistulas and we have generally employed the transverse loop colostomy.

A fourth point is obtaining a source of new vascularization. The necessity of this is described in the subsequent paragraph but suffice it to say that when the tissue is compromised and when there has been insult involving small vessel damage, healing will not occur without a good blood supply.

The fifth point is one of basic technical precision. The principles of wide mobilization, freshened edges, and careful approximation of layers is a basic essential.

Pathology vs. Principles

The radiation injury consists of endarteritis, necrosis, slough, and fistula produces a fistulous defect surrounded by a perimeter of significantly compromised tissue. This is evident clinically by its fibrotic, fixed consistency on palpation and its blanched appearance on palpation. This setting is in conflict with the principles that are standard for the closure of the fistula or the closure of a ruptured viscus. These specifically include: (1) a suture line without tension (2) no infection (3) good blood supply.

A variety of vascular pedicles have been described in the literature and include the rectus abdominis muscle, the greater omentum, the gracilis muscle, and the abductor longus muscle, the sartorius muscle, a portion of the gluteus maximus and the bulbocavernosus muscle with labial fat pad. We have utilized the latter because of its proximity and the approach seemed direct and uncomplicated.

Credit must be given to Martius¹ for describing the bulbocavernosus flap or labial fat pad method in the late 1920's. We have described and illustrated this technique elsewhere.² After the initial layer of the fistula is closed an incision is made over the mid point of the labia majora, one develops a flap of fat and the bulbocavernous muscle. It is swung into the vagina keeping the base posteriorly for a rectal fistula closure and anteriorly for a vesical fistula closure. The created flap is drawn under the vulvar skin through a separate incision. It is then approximated to the contralateral angle of the fistula closure thus interposing a layer of muscle, fat and good blood supply upon the first suture line. The vaginal side of the fistula is closed. The vulvar skin is closed and

all areas are appropriately drained and the pressure dressing is applied to the labial defect.

Our initial series reported in 1970 involved 10 defects and 8 successful closures. A composite of current total experience is recorded in Tables 1 and 2. It is evident that our best success has been with

TABLE 2
FISTULA CLOSURE SUCCESS

	1967-70		1970-72		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Rectovaginal	7/8	87	7/9	78	14/17	82
Urethrovesicovaginal .	1/2	50	—	—	1/4	25
Vesicovaginal	—	—	0/2	0		
Totals	8/10	80	7/11	64	15/21	71

rectal fistulas in spite of the relatively large size of the defects. It is this author's impression that there is a little more substance of tissue of the involved septum of the rectal fistulas than with the vaginal fistulas, and in spite of some success it seems more difficult to mobilize healthy tissue with these defects. An additional factor that we have experienced has been the relative inaccessibility of fistulas high in the vault when the upper vagina is narrowed by radiation injury.

Comment

The complicated vaginal fistula is not always amenable to conventional closure techniques and the literature has conveyed a rather pessimistic opinion, particularly with radiation induced fistulas. Often the first and definitive approach to these defects is diversion either with the ileal conduit or permanent colostomy. Our experience suggests that frustration and abandonment are not justified until all efforts at vaginal closure have been expended. It is gratifying to report that in many instances, even the majority of instances, these patients will be rewarded with successful rehabilitation.

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Peritonsillar Abscess—A Different Approach

MARSHALL STROME, M.D.,* *Boston, Massachusetts*

QUINSY WAS COINED in the 1800's as a descriptive phrase for what is more commonly known as peritonsillar abscess. For over a century now, the standard of therapy has been incision and drainage. The introduction of antibiotics on a national scale served to decrease the complications associated with peritonsillar abscess; yet the dogma of incision and drainage persists. Twenty patients with peritonsillar abscess are reported. In these patients antibiotic administration was followed by aspiration. Tonsillectomy was performed at a later date. Relief following aspiration was profound, discomfort from the procedure was minimal, and recovery swift. There were no complications.

Peritonsillar abscess, in most instances, is a complication of acute tonsillitis. Infection, usually in patients with deep tonsillar crypts, penetrates the tonsillar capsule, entering the potential space between tonsil and superior constrictor muscle. Suppuration occurs, and an abscess forms. Rarely is a peritonsillar abscess seen before the teenage years. The age range in this series was from 16-25 years.

Acute tonsillitis was the primary infection leading to abscess in all these patients. The time interval, from the onset of symptomatic infection until an abscess was detected, ranged from two to eight days. Patients started on antibiotics by referring physicians presented the latest; however, histories of increasing pain and progressive dysphagia suggested, in many instances, that relief could have been more prompt had specialty care been sought earlier.

Signs and Symptoms

Awareness of peritonsillar abscess should come before the classic signs are detected. The six *de novo* cases detected in this series never developed trismus. Increasing temperature and increasing pain prompted the patients to seek help. Increasing pain in a young patient with tonsillitis should increase the suspicion of a peritonsillar abscess. Initially, the pain is localized behind the angle of the mandible. Otalgia and

subsequent trismus herald progression of the infectious process. In the advanced state dysphagia is severe, salivation pronounced and the speech slurred. With dysphagia and pyrexia, dehydration can be significant. In two cases in this group bilateral abscesses were present and in these cases airway obstruction was significant.

Intraoral examination reveals a tonsil displaced medially. As the infection increases the tonsil is also displaced downward. There is marked swelling and erythema of the soft palate and uvula. In the advanced case, opening the mouth causes significant patient discomfort. Lymphadenopathy is present on the involved side.

Rarely is a peritonsillar abscess confused with another lesion; yet, the differential diagnosis must include peritonsillitis, lymphoma, and severe mononucleosis. Entities which must not be confused with peritonsillar abscess are parapharyngeal space neoplasms, gummas and vascular lesions.

Peritonsillitis is the most difficult to differentiate on a clinical basis. Classically, the tonsil is not displaced and the uvula, although swollen, is midline. In reality, the distinction is artificial, and only aspiration can differentiate the two entities with some degree of certainty.

Complications

Once pus forms it should be removed. Spontaneous resolution in healthy subjects is possible with spontaneous rupture in a week to 10 days; however, a wait and see attitude, even with the introduction of antibiotics, is not advisable. Should the abscess rupture during sleep, aspiration with ensuing pulmonary infection, is possible. Parapharyngeal space infection, vascular thrombosis, septic emboli and progressive airway obstruction are potential and exceedingly dangerous sequelae which early aspiration can prevent. All too often a physician's past experience with incision and drainage has created a dilemma, because the procedure has not proven to be innocuous. Deaths, although rare, and significant hemorrhage, have been reported.¹ More commonly, a

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painful incision is made, brisk bleeding ensues, and pus is not released. This type of experience has led to the philosophy of waiting until a soft area can be palpated prior to performing incision and drainage. Each hour of delay increases patient morbidity and the likelihood of serious complication. Aspiration ends the wait, decreases the morbidity, and speeds resolution of the infection.

Treatment is divided into two groups—hospitalized care and home care. Hospitalization is usually required in the advanced case. Specific indications for hospitalization include dehydration, inability to swallow, severe trismus and a jeopardized airway. A culture is immediately obtained by the conventional swab technique, and the aspirated material is also sent for culture and sensitivity.

Intravenous fluids and high doses of intravenous antibiotics are administered. Penicillin remains the antibiotic of choice. Linocin is the second choice for the penicillin sensitive patient.

Most patients do not require hospitalization, even though pus is obtained on aspiration. The home care patient is managed by immediate aspiration, culture and an initial intramuscular injection of Penicillin or Lincocin. Oral antibiotics are started at the same time. Oral antibiotics are continued in both groups for a minimum of 10 days; thereafter, they are stopped only when all clinical evidence of infection has subsided. All home care patients are re-evaluated in 24 hours and, if indicated, a second aspiration is performed. Additional supportive measures are employed in both groups. Oral fluids are forced when possible. Analgesics are prescribed on a symptomatic basis. Warm saline gargles are alternated with warm salicylate gargles. Salicylates used as a gargle serve a two-fold purpose: antipyrexia and topical analgesia. Because of the high incidence of recurrent infection, tonsillectomy is performed 4-6 weeks following resolution of the infection.

Technique

There is some question as to the efficacy of topical anesthesia with a peritonsillar abscess. I feel that it is indicated if for none other than psychological reasons. Cetacaine spray was used in all of these cases. Topical cocaine 10 percent with or without adrenalin is a good alternative. A No. 18 spinal needle with a 20 cc syringe is used. The patient is seated with an open mouth. All secretions are suctioned away. The area of induration is palpated. If a soft area is palpable this area is aspirated; otherwise, the most prominent area is selected. This will usually be the midpoint on an imaginary line extending from the base of the uvula to the upper third molar. Once into the tissue, negative pressure is applied to the syringe, and the needle is advanced until pus is obtained. Should the first aspiration be non-

productive and a high index of suspicion exist, unlike incision and drainage, several more aspirations may be attempted. Quite often the novice will find that the first aspiration site was not lateral enough.

Remarks

All patients had a culture and sensitivity performed. Fourteen patients were taking antibiotics at the time our culture was taken. Ten of the treated group had no growth. The remaining four had been on antibiotics for less than 36 hours prior to culture. The organism recovered in these cases was beta hemolytic streptococcus. The six untreated cases also had beta hemolytic streptococcus as the predominant organism.

The amount of pus obtained on initial aspiration ranged from 2 to 12 cc. Repeat aspiration was necessary in only four cases in 24 hours. All of these patients had greater than 6 cc at initial aspiration. Two cc of pus was the maximum obtained at the second removal. Those patients requiring a second procedure were again checked in 24 hours, and, in no instance was a third aspiration indicated.

The safety of the aspiration technique was proven. In no instance was bleeding a problem nor has it been in subsequent cases. In no instance was there an extension of the infection. None of the severe complications already discussed occurred; in fact, in two cases with bilateral abscesses significant respiratory problems were promptly relieved with aspiration.

Subjectively, patients undergoing aspiration had much less pain than with incision and drainage. Two patients in this group had undergone previous incision and drainage elsewhere and had refused tonsillectomy. They had vivid recollections of their earlier painful procedures. Both felt aspiration to be virtually pain-free in comparison with their previous experience.

Home care was shown to be an effective method of management for the uncomplicated peritonsillar abscess. A high index of suspicion coupled with aspiration can significantly decrease the need for hospitalization and greatly speed recovery.

Two questions remain: Is there a place for incision and drainage in treating peritonsillar abscess? Is there still a place for abscess tonsillectomy?

Aspiration and antibiotics are all that is necessary for the uncomplicated abscess. There are potential indications for incision and drainage. One case has been reported¹ in which the pus was too thick for aspiration. Although unusual, this possibility does exist. If two aspirations separated by 24 hours are productive, and the third aspiration yields more than 2 cc of pus, incision and drainage is indicated. No such instance was encountered in this study. Incision and drainage should be performed in the face of im-

pending complications.

Abscess tonsillectomy has been performed for more than a century. I have never advocated the procedure. Hemorrhage, extension of the local inflammatory process and septicemia are all possible and needless sequelae. The operation had been advocated to spare the patient two painful procedures,

i.e. incision and drainage, and subsequent tonsillectomy. It had also been suggested for cases in which pus was suspected at the inferior pole of the tonsil. The aspiration technique provides an alternate method for managing these patients.

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HIGHLIGHTS OF THE 1972 AMA CLINICAL CONVENTION

The following summary of activities of the AMA House of Delegates is given for the purpose of touching upon the more important items undertaken at the 1972 Clinical Convention in Cincinnati, Ohio. It is not intended as a detailed report of all the actions taken.

The AMA House of Delegates met, received and considered a large number of reports and resolutions at its Clinical Convention in Cincinnati. The House of Delegates considered 124 separate items of business, including 59 reports from the AMA Board of Trustees, Councils and Committees. Sixty-five resolutions were proposed by state medical associations and section delegates. These included:

PSRO

The House of Delegates adopted a report from the Board of Trustees which stated that the AMA will "provide a dominant role of leadership in the implementation of the PSRO Program to assure that the best interest of the public and the profession are preserved."

An AMA Advisory Committee on Professional Standards Review will be created by the Board of Trustees and will include members of the Board, the Council of Medical Services, and possibly, other appropriate organizations.

Among responsibilities of the Advisory Committee are the following:

- (1) To provide input from the medical profession in the development of rules and regulations which will govern the PSRO Program.

- (2) To assist state medical associations or state medical associations in concert with county medical societies in developing PSRO's and to recommend structures and operating mechanisms for such organizations.

- (3) To aid in defining appropriate geographic boundaries for PSRO's, especially where more than one state may be involved.

IRS Ruling

The House was informed that an Internal Revenue Service ruling—which barred physicians from withdrawing voluntary contributions to their Keogh Law Plan prior to disability or age 59½—will be revised to permit withdrawal of such contributions made to a qualified plan prior to March 6, 1972. The AMA had vigorously protested the ruling and delegates complimented the AMA staff for its "prompt and effective action."

Since the House of Delegates in 1971 urged creation of state and local medical society committees concerned with health care of the poor, 23 states and 29 local societies have set up such panels. They are currently developing programs to improve health care services. This progress note was included in a report of the Council of Medical Service, which the House urged be given wide distribution. The report emphasized that local systems must be developed to meet local needs.

On related measures, the House urged organized medicine to continue to provide assistance and work to improve the quality of care in free clinics, which are increasing in number around the nation. Currently, there are more than 200 of them in 30 states.

The House also approved a statement on the concept of health outreach, whereby lay workers serve to bridge the cultural gap between patients, professional staff and the community and assist in effective delivery of health care. Among the several reasons advanced by the report for using such workers was that they free doctors and other health professionals to better utilize their time and thus, extend the scope of their services. The statement recommends that the AMA, state and local medical societies encourage the use of such personnel and that the AMA institute educational activities for physicians and other health professionals on the use of outreach workers.

Young Physicians

The House approved a report to include on the Council of Long Range Planning and Development, one intern and resident member of the AMA as a full voting member of the Council.

For the first time in the history of the AMA, a medical student took his seat in the House of Delegates. He is George Blatti, a senior medical student at the University of Minnesota Medical School. In another action, the House set annual dues for student AMA members at \$15.

Elections

Three AMA members of the new coordinating Council on Medical Education were elected by the House of Delegates. They are: Merrill O. Hines, Louisiana; Bernard J. Pisani, New York and Tom E. Nesbitt, Tennessee.

The methods used in a comprehensive clinic are outlined and follow-up studies are described.

Convulsive Disorders: A Team Approach

GARY D. MCCRORY, M.Ed.,* *Columbus*

THIS IS AN EFFORT to outline the workings of a new approach in the rehabilitation of patients with seizure disorders. In cooperation with the Georgia Office of Rehabilitation Services, the Columbus Medical Center and Dr. Louis A. Hazouri, the clinic physician, a comprehensive clinic has been developed. The clinic began operation in December of 1969. The purpose of this paper includes outlining the methods used by the clinic and reporting on a follow-up study.

In addition, it is felt that the statistics reported may be useful. People interested in helping patients with seizure problems will be able to weigh the results and determine whether such ideas should be considered in other locations. It is also hoped that this writing might generate thoughts toward developing other new programs.

A review of the literature, *Index Medicus*, gives relatively few articles concerning such multidisciplinary clinics as will be discussed here.

Twenty-nine chronic idiopathic epileptics and 44 with symptomatic epilepsy, were treated by Ross and Jackson over a period of 12 to 18 months.⁴ This study shows the effect of Dilantin (diphenylhydantoin) in reducing seizure frequency and in causing changes in psychometric scores. The authors found that seizure frequency was reduced in 65 per cent of these patients.

Dr. Alex J. Arieff gives some data showing that 50 per cent of patients, with seizures, treated routinely with anticonvulsant medication, are easily "rehabilitated" and generally do not require other

specialized treatment. However, he goes on to show that 20 to 40 per cent of seizure patients have psychological and/or social problems that must be dealt with. He also indicates that there is a need for a complex and comprehensive approach to treatment of the epileptic:¹

In a patient with an epileptic disorder, it should go without saying that a complex diagnostic evaluation is necessary to fully understand the symptoms, possible cause, and treatment. This should include detailed history, including the family; detailed physical and neurological examination; detailed description of the seizures from the patient and from an observer; skull x-ray; electroencephalogram; psychological and social evaluations and possibly a brain scan. (pp1249)

Even Friedlander, et al.,² in their extensive review of the literature mention no such comprehensive treatment programs. Doubtless, there are many "team-approach" clinics, but there appears to be a need for more work in this area.

What is the structure of our clinic? How does it meet these psychological and social needs?

Operation of the Clinic

The treatment program begins when the local rehabilitation counselor receives a referral either from the patient/client's hometown physician, or from some service agency such as the Department of Family and Children Services. When beginning treatment in the clinic, all patients receive a comprehensive evaluation. This is in three main areas:

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- 1. Vocational/Social—Rehabilitation Counselor
- 2. Psychological—Clinical Psychologist
- 3. Neurological—Clinic Physician

1. Vocational Evaluation

Vocational evaluation is extensive. Each patient is given vocational testing as well as a thorough interview concerning his interests and previous work experience. Social information is taken and efforts made to cope with social and other problems which could hinder the patient's treatment program. These will be discussed later.

2. Psychological Evaluation

A clinical psychologist has worked with this clinic over the past three years on a nominal fee for service basis. Each patient receives a complete psychological work-up to include intelligence testing and projective testing. The Wechsler Adult Intelligence Scale and the Bender Gestalt are used. Special notice is taken of any contributing emotional problems as well as any indications of organic involvement. The psychologist also helps by giving his opinion of the patient's vocational prognosis.

3. Neurological Aspects

Conventional diagnostic tools are employed including EEG, lab and x-ray evaluation and neurological examination. All procedures mentioned in Dr. Arieff's remarks are considered and performed if indicated. Anticonvulsant medication is recommended. These drugs may be supplemented by, or replaced by, other drugs and the dosages changed as indicated until best control is obtained. Any specialized treatment such as psychiatric treatment, dental treatment, and medical treatment is arranged if needed.

Five to seven patients are seen twice each month with never more than two of these being new and requiring the extensive evaluation. A small personalized clinic is maintained.

Special Services

Epileptics are employable but need guidance and psychological counseling.³ Each patient is provided

counseling for encouragement. In addition, each patient gets special attention to help with any questions he may have concerning his particular rehabilitation program. Patients are followed closely and urged to stay on their medication, lost medicines are replaced.

Furthermore, financial assistance is provided for such important items as travel expense, specialized treatment, room and board where applicable, and the purchase of medicines. This aid is given until such time as the patient has been successfully placed in employment for a reasonable period and his seizures controlled or until it is determined that services can be of no further benefit to the patient.

A Follow-Up Study

Over the period of 18 months, preceding April 1972, a survey was taken. There were 33 patients in treatment for all or part of the 18 months. Each area rehabilitation counselor was given a questionnaire inquiring about the progress made by his patient/clients. Since these rehabilitation counselors are at the most not even para-medical, the only responses used in the study are those concerning work status (work as used here, denotes working or in training) and frequency of seizures. The survey included questions about the severity of seizures but these responses were not felt to be valid for use here.

Each local rehabilitation counselor interviewed his client or clients and asked whether they were taking the medication and whether the seizure frequency had changed since beginning the rehabilitation program. Also, vocational changes were recorded. Seizure frequency was reduced in 79.8 per cent of the patients. Vocational improvement was noted to be significant, 60.6 per cent were in work status at the time of the study (Table 1).

As a control group, thirty-three seizure patients in the same age range were selected at random from the charts of The Medical Center, Out-Patient Clinic. This group has its limitations as a control group because no effort could be made to match the patients by I.Q., sex or education level.

A survey was made of the charts and entries tabulated. Any entry stating that seizures were "under control" was counted as improved. Entries indicating no improvement were also tabulated. Reduction of

TABLE 1
EXPERIMENTAL GROUP

Descriptive Data		Results of Study	
Average ed. grade level	9.6	Number of patients	33
Average reading grade level	4.5	Number improved	26
Average I.Q.	79	Number working at survey	20 (60.6%)
Median I.Q.	79	Number seizure free 12+ months	6

seizure frequency was found in 49.5 per cent of patients surveyed (Figure 1).

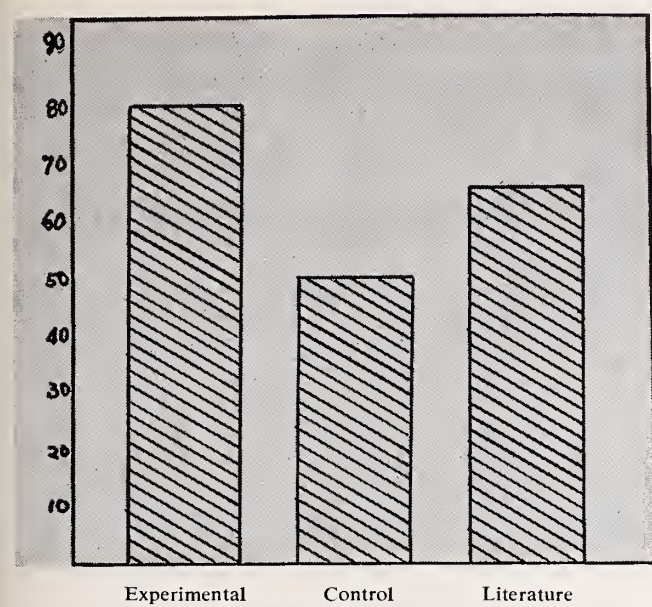


FIGURE 1
A Comparison of Groups

Some data was tabulated to indicate characteristics of the population in the experimental group. For instance, the mean I.Q., was below 80 and the educational grade level, as well as the functional level, was also very low (Table 1).

A comparison of data by use of non-parametric statistical analysis was made. Using 65 per cent improvement as the expected rate, the Chi square test shows the data significant at 0.13 (this improvement percentage could occur by chance only 13 times out of 100).

Using Dr. Arieff's findings of 50 per cent as the expected number of patients who could be controlled by simple medical management, it is easily seen that our clinic has reached into the group requiring additional special services and has been effective.

Conclusions

It has been shown that giving attention to psychological, social, and vocational problems of seizure patients, produces significant results. Our comprehensive approach shows 79.8 per cent of patients with improvement in seizure control. Greater than 60 per cent had attained "work" status at time of the study.

This multiple discipline approach appears to be superior to the conventional method which, in this study, only shows about 49.5 per cent of the patients as having improvement in seizure frequency. Considering the population being "treated" (Table 1), these results seem to indicate that progress is being made in providing meaningful help for the patient/client with epilepsy.

The Medical Center
P.O. Box 951 31902

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3. Frank, D. S.: Group counseling benefits. Job seekers with epilepsy. *Rehab. Rc.* 9:34-37, 1968.
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HIGHLIGHTS OF COUNCIL
December 9-10, 1972

Board of Human Resources: Received report from chairman on issues under consideration: (1) extension of dental services; (2) including chiropractic services under Medicaid; (3) redefining role and relationships of Office of Comprehensive Health Planning; (4) limiting activities of Central State Hospital and using it as regional hospital for Middle Georgia.

Constitution and By-Laws: Approved for presentation to House of Delegates, language to provide full rating membership for interns and residents.

Legislative Report: Reviewed legislation of interest to MAG to be introduced this session. Requested legal counsel to continue investigating legislation to protect confidentiality of patient records and findings of medical review committees.

Georgia Medical Care Foundation: Appointed Henry D. Scoggins, M.D., Augusta, and Robert S. Tether, M.D., Gainesville, to the Foundation's Board of Directors.

House of Delegates Actions: Accepted letter of Department of HEW concerning use of EMCRO data by MAG as directed by House of Delegates.

GaMPAC: New Officers: Chairman, J. Daniel Bateman, M.D., Albany; Co-Chairman (Women), Mrs. J. Daniel Bateman, Albany; Vice Chairman, Luther M. Vinton, Jr., M.D., Avondale Estates; Secretary-Treasurer, Earnest C. Atkins, M.D., Decatur; Member-at-Large, Stuart Prather, M.D., Augusta; Member-at-Large, J. Frank Walker, M.D., Atlanta.

AMA Report: Received AMA Delegates Chairman's report on actions taken at Clinical Meeting including: (1) economy cuts made by reducing numbers of Councils and Committees; (2) support and assistance encouraged for development of PSRO's.

Regional Medical Program: Confirmed election of A. H. Letton, M.D., Atlanta, as chairman of Regional Advisory Group.

Next Meeting: March 10-11, 1973, Savannah.

Evaluating, then improving upon the quality of patient care requires a carefully developed peer review mechanism.

Continuing Education in the Community Hospital—The Role of Peer Review

J. GORDON BARROW, M.D.,* *Atlanta*

CONTINUING EDUCATION of the practicing physician is increasingly becoming the responsibility of the community hospital.

In order to design an effective program of continuing education, it is necessary to consider the eventual goal of this education. It is my opinion that the only legitimate goal for continuing education is improved patient care. If this premise is accepted, it will be necessary to keep this goal firmly in mind while designing any continuing education program.

In order to achieve better patient care it is first necessary to set criteria, acceptable to the physicians for ideal patient care. Measuring success in reaching these ideals requires an organized system of peer review.

One of the problems of our present peer review system is that the criteria for ideal care are often assumed by the peer review group or individual reviewer at the time the record is being examined and the physician whose chart is being examined has not had an opportunity to know the criteria by which he is being judged prior to his treatment of the patient. Peer review can only be successful if the staff agrees to criteria for ideal care prior to the inauguration of the peer review process. It is important that only the charts of patients admitted after the staff has agreed on these standards be included in the peer review. In this way each doctor may participate in setting the criteria for ideal care and is fully aware of what is expected of him before he treats the patient.

Because it is impossible to arrive at criteria for ideal care in the thousands of potential diagnoses in patients admitted to the average community hospital over the period of a year, it is necessary that some priorities be set and that criteria for ideal care be adopted for those conditions most frequently

treated in the hospital, and those where existing patterns of care are felt to need the most improvement. Since criteria for ideal patient care are continually changing as new advances in all fields are made, a regular periodic review of the criteria which have been adopted by the staff must be undertaken.

Another integral part of the peer review procedure is adoption by the hospital staff of the elements of history, physical examination, treatment and progress recording which must be the minimum acceptable medical record. Any peer review mechanism is totally dependent on good medical records and each physician must be aware of what is expected of him in this regard. Where it has been used, the Weed system of problem oriented medical records has proven to be an extremely valuable tool for peer review however any good system of medical records can be used successfully.

The second step in the process is to evaluate current records of patient care in terms of the ideals which have been adopted by the staff. If the criteria are clearly defined, a good medical record librarian who has been trained in medical audit can do much of the preliminary work in reviewing the charts and identifying deficiencies according to the criteria which have been adopted. These deficiencies may be of two types: 1) pertinent information may not have been recorded on the chart; 2) the patient care recorded appears to fall short of the ideal adopted by the medical staff. The peer review process can then proceed rapidly to identify the conditions being least effectively handled by the staff of the hospital as well as the physicians on the staff who are most deficient in their performance.

It is most important that no punitive action be connected with this initial peer review. It should be entirely a constructive peer review with the purpose of measuring where corrective continuing education is needed by the staff and what type of continuing

* Director, Georgia Regional Medical Program.

education this should be. The point should be made here that many hospitals have an excellent program of continuing education, but since the education has no relationship to peer review, it may have little value as corrective education for those deficiencies that actually exist.

Identify Needs

The next step in the process is to design the corrective education. For this purpose a Director of Medical Education is extremely helpful. When community hospitals first began to employ Directors of Medical Education, their only responsibility was to recruit and train house staff. Experience has shown that this should not be their most important function since no successful house staff program can be implemented in an institution where medical care of all the practicing professionals does not meet a very high standard of excellence. It has therefore become more and more the responsibility of the Director of Medical Education to identify the continuing education needs of the staff and to design appropriate educational experiences to correct these deficiencies. In hospitals without a Director of Medical Education, the Chiefs of Service or Chief of Staff should assume this function. Assistance is available through the Visiting Consultant Program of the Georgia Regional Medical Program if desired.

The fourth step is to motivate the health professional to participate in the Education Programs. It has been my experience that this is not a difficult task if a punitive approach is not taken, and if the health professional can be shown through peer review that criteria previously agreed upon by the entire staff have not been met in the care of his patients. It is a rare occasion when a physician shows little interest in improving his patient care and continually fails to respond to suggestions of corrective continuing education. In that case the Chief of Service or Chief of Staff must take firm action to make sure that the standards of the hospital are maintained. The Director of Medical Education or Peer Review Committee should never have the respon-

sibility for this punitive action. Their role should be limited to assisting the physicians to identify their needs and to meeting the needs in the most efficient and effective manner possible.

In order to evaluate the results of continuing medical education, both short and long term results on patient care should be measured. Both long and short term must be emphasized since it has been shown that although short term improvement may occur, after some types of continuing education, long term results may not be as effective. It is only if patient care has improved over the long term that continuing education may be considered to be truly successful. This periodic review then becomes another important role of peer review.

It is necessary that a substantial amount of hospital budget and staff time be devoted to this program of continuing peer review and corrective continuing education. It is estimated that, in an average 300 bed community hospital, the cost of this total program (including both peer review and continuing education) may be in the neighborhood of \$50,000 per year. However, in hospitals where it has been successfully implemented it has proven so effective in improving patient care that its continued financing usually presents no major problem.

Certainly some of the smaller hospitals in the state cannot afford such an ambitious program. It is often necessary for these hospitals to turn to neighboring larger hospitals for assistance in carrying out such a program. The Georgia Regional Medical Program over the past three years has attempted to develop Continuing Education Area Facilities. These are located at larger community hospitals which are capable of developing good continuing education programs of their own, and if requested can provide assistance to the smaller hospitals in their area in carrying out a similar though less extensive program. Limited financial assistance is available to both the area facility hospital and the smaller community hospitals to demonstrate these programs initially until they can become self supporting.

938 Peachtree Street, N.E. 30309

MAG PERSONNEL CHANGE

Charlie Templeton, 32, has associated with the Medical Association of Georgia as of December 1 as director of public and professional relations.

The Atlanta native received his A.B. degree in journalism from Georgia State University and served six years in the National Guard.

He has extensive experience in public contact related fields, operating a travel agency in Athens and later working in passenger service department for Delta Air-

lines. Mr. Templeton came to MAG from National-Southwire Aluminum Co. in Hawesville, Ky. where he served first as a public relations supervisor, then moving to the position of corporate manager of public relations and advertising.

Married to the former Janet Mixson of Atlanta, Mr. Templeton has two children, Sigrid, 2, and Hayden, six months.

Indicated in the report is the widespread interest of a broad segment of individuals in the advancement of ambulance service.

MAG, the Regulations and Georgia's Ambulance Statute

CARL JELENKO, III, M.D.,* *Augusta*

DURING THE 1972 LEGISLATIVE SESSION, the Georgia General Assembly adopted HB370, a statute which regulates ambulance services in the state of Georgia. The specific provisions of the regulations, however, are within the purview of the Emergency Health Unit of the Division of Physical Health. Accordingly, an ad hoc committee was convened which studied the law and drew up a series of recommendations which will be subject to public hearings, probably in January of 1973.

Certain of the provisions of the regulations were deemed to be extremely critical to maintenance of ambulance services in Georgia. Particularly, it was recognized by the ad hoc committee that 50 to 60 per cent of ambulance services in Georgia are provided by funeral directors, but that by July 1973 those funeral directors remaining in the ambulance business may be reduced to as low as 40 per cent; and gradually, over a period of time, further reduced to 25 per cent. It was also recognized that the tenor of the provisions promulgated would act in a significant manner to retard or enhance the rate at which non-governmental ambulance services are continued in Georgia. The Committee recognized a ground-swell of public opinion toward generating retrogressive legislation that might go so far as to attempt to repeal the ambulance statute; and recognized that the two primary areas of concern were the training provisions and the provisions relative to the size and shape of the ambulance itself.

Accordingly, on November 18, 1972, an extraordinary combined meeting was held at the Medical Association of Georgia Headquarters between the Emergency Medical Services Committee of MAG acting as host, and the Trauma Committee of the American College of Surgeons. Invited were the

memberships of both organizations and members from the Georgia Department of Human Resources, Georgia Hospital Association, Georgia Department of Public Safety, Georgia Office of Highway Safety, the Atlanta Area Regional Council, Georgia Regional Medical Programs, M.A.S.T., the Emergency Health Services Unit, the Georgia Funeral Association and the Georgia Department of Planning and Budget. In all, 23 individuals attended and participated in this meeting which was called to review and offer recommendations relative to the Proposed Regulations for Ambulance Services.

The meeting began with a comprehensive review of the background of the new ambulance statute and the current "state of the art." Next, the various areas of concern were discussed in detail and the group made recommendations which will be offered at the time of the hearing on the regulations. The pertinent findings and recommendations follow:

Training: After considerable discussion, it was agreed unanimously that maximum training should be accomplished by the earliest possible date. It was also recognized that a reasonable amount of time had to be allowed providers to enable them to get their personnel trained. Further, it was recognized that all individuals hired after Jan. 1, 1973 would be required to have completed advanced Red Cross training prior to being hired and to complete the Department of Transportation (D.O.T.) Emergency Medical Technicians/Ambulance (EMT/A) Course within 9 months of being hired. The ambulance statute provides that for those personnel already hired as of the effective date of the law (January 1, 1973) a minimum of 2 years would be provided within which time all training requirements would be met. A motion was passed to accept the training schedule as proposed by the ad hoc committee which will provide that all ambulance attendants must have completed at least advanced Red Cross training by Sep-

* Associate Professor of Surgery, Medical College of Georgia, Chairman, EMS Committee.

tember 1, 1973 and the D.O.T. EMT/A Course by September 1, 1975.

Personnel: The current regulations as written did not specify that the ambulance attendants be required to remain within the patient's compartment during transport of patients. It was urged that the adopted regulations *do* contain such provisions.

Further, a motion was passed stating that "the driver" of the ambulance "will be required to have completed the National Safety Council Defensive Driving Course or its equivalent, and the Red Cross Standard First Aid Course or its equivalent, which training will be completed within a time-frame which is the same as the training schedule for Attendants."

Equipment: It was emphasized that all additional training which might be necessary for EMT/A personnel to utilize their equipment properly and efficiently should be given.

The Ambulance: The group recommended no changes in the regulations pertaining to the size and shape of the ambulance. It was emphasized that wherever D.O.T. funds were to be used to purchase such vehicles, the specifications of that Department must be followed for vehicle configuration. A motion was passed which stated that "Department of Transportation specifications will be maintained with regard to size and shape of ambulances by the Department of Human Resources when funds are being allocated for ambulance purchase by the State." A

further motion was passed to accept "... the regulations as written with regard to size and shape of vehicles and to annually re-evaluate regulations pertaining to size and shape of ambulances in Georgia."

Radios: A motion passed that "each ambulance shall be equipped with a short-wave 2-way radio approved by the Department of Human Resources."

Technical Advisory Council: It was moved and passed unanimously that "a Technical Advisory Council on Emergency Medical Services be established by the Department of Human Resources for the purpose of advising the Department on a continuing basis in the area of policies and procedures in emergency medical services." A further motion passed unanimously indicating that "... Emergency Medical Services Technical Advisory Council be required to review these regulations on an annual basis. . . ."

The information above should provide considerable information of interest to the physicians of Georgia. It should indicate to them the widespread, detailed interest of a broad segment of individuals and groups in the state in the advancement of ambulance services. It is anticipated that these regulations will be adopted after public hearing with little difficulty, thereby providing a profound impetus for developing efficient, skilled, thoughtful ambulance services throughout our state!

Medical College of Georgia 30902

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

December 9-10, 1972

Appointments: William J. Morton, M.D., Cairo, to Ad Hoc Committee on Medical Disciplinary Board; Alvin W. North, M.D., Atlanta, to Inter-professional Council of Georgia; to Ad Hoc Committee on Geriatric Medicine: Joseph S. Cruise, M.D., Atlanta; William A. Futch, M.D., Conyers; George Green, M.D., Sparta; Ralph A. Murphy, M.D., Atlanta; John H. Robbins, M.D., Athens; Joseph S. Wilson, M.D., Atlanta; Joseph D. Rawlings, M.D., Thomasville; R. S. Robinson, M.D., Metter; John L. Henley, M.D., Millen; and Carl Aven, M.D., Atlanta.

Building Expansion: Approved continued investigation of purchase of site or building on outskirts of Atlanta for MAG Headquarters Office.

County Society Membership: Referred to Committee on Constitution and By-Laws the making of membership in a county society by the physician's practice location, optional at the discretion of MAG Executive Committee.

Utilization Review Committees: Referred to Committee on Private Practice the question of the possibility of URC members being compensated for their services by the hospital.

Interspecialty Council: Approved sending all member mailing to solicit comments on specialty society relationships to MAG.

Georgia Medical Care Foundation: Received report on (1) suspension of HMO development activities in Peach Belt Medical Society; (2) programming delays in putting Medicaid Review on computer; (3) development of PSRO's possible in areas of Georgia with 300 or more physicians.

EMCRO: Approved submission of grant proposal for development of Health Statistics System.

Board of Human Resources: Heard report on Board activities which include review of HMO legislation and appointment of committee to study chiropractic.

Next Meeting: Sunday, January 14, 1973, MAG Headquarters Building, Atlanta.

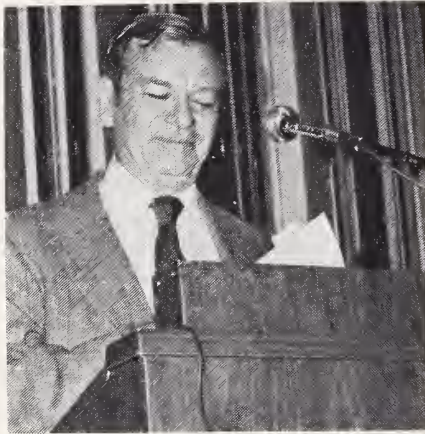


THE PHYSICIAN'S role in politics and legislation, with emphasis on bills relating to chiropractics, highlighted the November 1972 MAGNET Conference in Atlanta. Over 30 legislators responded to the invitation of MAG and attended some portion of the two-day meeting. Among these legislators was George L. Smith, Speaker of the House (above right), who assures conference presiding chairman H. Duane Blair, M.D. that the opinions and comments of medical doctors are welcomed by members of the General Assembly.

Two Florida physicians who have carried political involvement to the point of being elected to office urged Georgians to get interested in government processes and counterbalance the persistent lobby of opposing groups. Sen. David C. Lane (seated, above left) and Rep. Richard S. Hodes reviewed efforts in their native state to curtail the activities of chiropractors by requiring the establishment of accredited schools for practitioners in every phase of the healing arts.

Georgia's senior senator, the Honorable Herman Talmadge (left), delivered the most recent information available on the course of health legislation on a national scope, specifically H.R. 1 or Public Law 92-603.

MAGNET Conference participants were provided first-hand information on the dangers of chiropractic by Ralph Lee Smith (below), author of "At Your Own Risk" who conducted research nationally into the education and techniques of chiropractors.



M A G N E T C O N F E R E N C E

The most recent information available on health care legislation was presented in this address.

The Citizen's Role in Politics and Legislation

HONORABLE HERMAN TALMADGE, U.S. SENATOR, *Washington, D.C.**

AS ALWAYS, I appreciate the invitation to visit with you fine folks who are doing so much to improve the health care of Georgians to discuss current and anticipated legislation in the health care programs.

The biggest new development in health care legislation, of course, is H.R. 1, with its many, many provisions expanding and changing Medicare and Medicaid.

Frankly, for about a week, I wasn't sure whether I would be able to tell you anything.

It was touch and go with H.R. 1 walking a tightrope at the White House in terms of whether President Nixon would sign the bill.

In fact, this was almost a tightrope on top of a tightrope because the Congress completed action on H.R. 1 almost on the eve of adjournment.

But, the bill has been signed into law.

Now the question is not whether H.R. 1 will become law, but how it will be administered.

As most of you know, the Congress and the Senate Finance Committee in particular labored long and hard to develop the changes—hopefully changes for the better—contained in H.R. 1.

I might add parenthetically that H.R. 1 was the legislation's "maiden name."

Now that it has been signed by the President, it is known as Public Law 92-603.

What many people don't realize is that legislative Committees, such as the Committee on Finance, have two major responsibilities:

First is the obvious one of considering and acting upon legislation, but the second, of perhaps equal importance, is the legislative oversight responsibility.

Legislative oversight essentially involves evaluation of the effects and administration of laws already on the books.

If prior experience is of any value, it can be anticipated that the Finance Committee will be doing

quite a bit of legislative oversight in the next few years with respect to the provisions in P.L. 92-603.

The Department of Health, Education, and Welfare is not noted for its administrative capability and sensitivity and the Committee is well aware that many of the Medicare and Medicaid provisions will demand careful administration.

Careful administration will be particularly important with respect to what is probably the most important single provision in the new law—the Professional Standards Review Organization Amendment.

That amendment, as you know, was supported, influenced and improved by the Medical Association of Georgia.

Bill Dowda is particularly deserving of special credit for his concerned and public spirited efforts.

The Conference Committee of the House and Senate on H.R. 1 indicated its expectation—and HEW agreed—that a task force of practicing physicians, experienced with various prototype review organizations, would be established to assist in implementing the PSRO program.

I am hopeful that Bill Dowda will be a member of that task force.

PSRO, to my mind, represents a solid opportunity for practicing physicians to responsibly answer the many and frequent criticisms of health care in this country.

There is no question but that some of the criticisms are justified.

On the other hand, it seemed to some of us that, when you really get down to it, there is just no alternative to the practicing physician and that the overwhelming majority of those practicing physicians are honorable and well motivated people.

I suspect I should probably say the same thing about many of the critics of medicine because they too are, in the main, honorable and well motivated.

Being honorable and well motivated, of course, doesn't necessarily make you right.

There is no question but that there will be greater

* Presented at the 1972 MAGNET Conference, October 11-12 in Stouffer's Atlanta Inn.

Federal involvement in the financing of health care in the near future.

Consequently, it became necessary to develop a means whereby the medical profession could provide assurances, in publicly accountable fashion, that only medically necessary care was being provided under the enormous Federal programs and that the care provided met professional standards.

I think you will agree that these are reasonable objectives but they are objectives which cannot be attained through the use of bureaucrats and insurance company clerks.

To achieve those objectives, we have to break down the distrust of organized medicine by many in Government and the deep distrust of Government by many in medicine.

We believe that PSRO's offer perhaps the only responsible answer to breaking down that distrust in favor of a cooperative effort based upon mutual respect.

I am hopeful that, with the leadership of the Medical Association of Georgia, several PSRO's will be functioning in Georgia by the end of next year.

As a matter of fact, because of the work you have already done, Georgia is probably ahead of most other states in the country in terms of getting PSRO's off the ground.

Just by way of reassurance, it should be understood that no one expects the PSRO's to spring into full blown operation.

We don't want avoidable delays, but, on the other hand, we don't want to experience the avoidable mistakes which come from too hasty implementation and operation.

I would anticipate that orderly, progressive assumption of responsibility by the PSRO's, as they increase their capability to do the necessary review, would be all we can ask.

PSRO represents an exciting opportunity for medicine and I want to assure you that we in Congress will do all we can to see to it that every possible assistance you require is provided.

There are other important provisions in P.L. 92-603 which are of obvious interest.

First, there is the extension of Medicare coverage to disabled Social Security beneficiaries who are under age 65.

It is estimated that on July 1, 1973, when the benefit becomes effective, some 50,000 disabled Social Security beneficiaries in Georgia would be covered by Medicare.

Related to coverage of the disabled is a special benefit for those unfortunate people who suffer chronic renal failure.

You doctors know better than I the terrible consequences of chronic renal failure.

Under the new law, workers covered under Social Security, as well as their spouses and dependents, would be covered under Medicare starting three months after a course of renal dialysis is begun.

The provision also covers the costs of kidney transplants.

While only a relatively few thousand people are actually affected by this provision, for many of them it can mean the difference between life and death.

It is my understanding that the Georgia Foundation has been doing an extensive amount of work in evaluating patient care and patient needs in nursing homes.

In this area, Public Law 92-603 made a number of significant changes designed to improve the quality of care while, at the same time, cutting red tape and easing the physician's job in determining whether his patient qualifies for skilled nursing care.

The first change provides for a single set of requirements for skilled nursing facilities under both Medicare and Medicaid and a single survey to determine whether those standards are complied with.

This will avoid the often separate surveys and separate and distinct standards which have characterized Medicare and Medicaid heretofore.

The definition of the level of care required for a patient to be placed in a skilled nursing facility was also changed.

Basically, the requirement for authorization of skilled nursing benefits is that the patient be in need of "skilled nursing care and/or skilled rehabilitative services on a daily basis (in a skilled nursing facility) which it is practical to provide only on an in-patient basis."

Obviously, that definition gives the practicing physicians substantially more discretion than they have had under Medicare and, to some extent, under Medicaid.

We do not feel that this liberalized definition will pose any particular problems in over-utilization because the PSRO's will be available to assure proper patient placement.

Another interesting amendment to Medicare authorizes payment for care which was found to be not covered under the program but where the patient acted in good faith and had no reason to know that the care was not covered.

This is designed to protect the patient who, after a month of care, finds that he owes a skilled nursing home a thousand dollars.

Another amendment would bring Medicare's recognition for reimbursement purposes of major capital expenditures by hospitals into line with existing

State and local health planning agencies and legislation.

Under this provision, if a hospital's proposed expansion were specifically disapproved by an area-wide planning agency, Medicare would not reimburse for any of the capital-related costs associated with that expansion.

Of course, appropriate appeals procedures are provided to safeguard against arbitrary decision-making.

There are so many Medicare and Medicaid amendments in H.R. 1 that I brought along a supply of booklets summarizing each of the amendments as time will not permit me to discuss with you more than a few additional significant changes.

You are certainly welcome to these summaries and I believe you will find them helpful.

The Health Maintenance Organization, or HMO, legislation is an area which has concerned many physicians, hospitals and others in the health care field.

It is an area where many have embraced the rhetoric without taking a long, careful look at what they were holding so near and dear.

The Finance Committee did an extensive amount of work on the HMO provisions relating to Medicare.

Virtually all of these were tightening changes designed to avoid abuses and to assure reasonable levels of proper care.

Surely there is not a physician here, or anywhere for that matter, who would argue against the thesis that comprehensive care is good when provided on an ongoing basis, stressing the maintenance of reasonable good health as opposed to solely treating the patient after he has become ill, or when his illness has progressed to serious proportions.

It is about as hard to quarrel with this premise as it is to argue against a cry for tax reform.

The real question with HMO's, as with tax reform, is in defining what those terms mean.

Basically, the approach the Finance Committee took, and which the Congress ultimately approved, was to avoid buying a "pig in a poke" and, instead, authorizing incentive reimbursement only to those organizations with demonstrated capability to provide proper care to a reasonably broad cross-section of the population.

For example, with the exception of rural areas, to be eligible for incentive reimbursement under Medicare, an HMO must have a minimum of 25,000 individuals enrolled and must have been in substantial operation for at least two years.

The virtue of this is that the minimum size requirement means that the insurance risk can be spread among a population of a size sufficient to

support those enrolled people who require extensive and costly care.

The two-year test means that it is possible to go in and determine whether necessary care is actually being provided and whether appropriate referrals are being made as well as whether the organization is utilizing qualified facilities and personnel in providing covered care.

There are quite a few other related requirements designed to safeguard public trust funds and assure adequate care.

I would also add that, unlike some other HMO legislation, the provisions for incentive reimbursement to HMO's under P.L. 92-603 do not discriminate against medical foundations which seek recognition as HMO's.

A qualified medical foundation which desires HMO status is treated on a par with a qualified prepaid group practice plan.

The point is that the objective is to utilize, regardless of sponsorship, whatever type of organized arrangement achieves the objective of coordinated care.

Payments are made on a capitation basis but from those amounts fee-for-service may be utilized by the HMO as the means of paying for physicians' services.

The Congress was not interested in labels but, rather, it was interested in results.

It may be that the HMO provisions in H.R. 1 are too tightly drawn and perhaps too restrictive, but I think you will agree with me that it is far better to loosen up those provisions at a later time than to go off the deep end now.

All of us have learned a great deal since the advent of Medicare and Medicaid and there is no point in disregarding that knowledge.

Those two programs, by the way, now cost \$20 billion a year.

During the next Congress, and perhaps that which follows it, a great deal of attention will be given to National Health Insurance proposals.

I expect and invite the constructive help of the Medical Association of Georgia as we on the Committee on Finance consider the various legislative proposals.

In that regard, I find the Medical Association of Georgia extremely helpful because you, unlike some other organizations, recognize that our laws are made on the basis of compromise—hopefully, reasonable compromise.

Consequently, you don't come in saying—"Do it my way or else."

It was that spirit of compromise and work toward responsible solutions which characterized your efforts on PSRO.

POLITICS / Talmadge

The politician's job, as you can appreciate, is complex and involves reconciling many legitimate and sometimes diverse interests.

Most of the time, that can be done only through compromise.

Those such as yourselves, who recognize this essential quality in the political process, are most effective in making their influence and views heard and acted upon.

It is the difference between discussing and demanding.

As you all know, the Medical Association of Georgia always has access to my office.

I suppose I might say that it is a pleasure doing business with you.

In the years—in fact, months—to come, many important issues affecting health care in general, and the practice of medicine in particular, will be considered in Washington.

I invite and welcome your professional input.

Thank you again for the helpful counsel you have offered in the past, and for your invitation this morning.

109 Russell Office Building 20510

Hill Crest **HOSPITAL**

Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.

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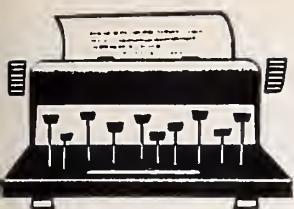
A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

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Charles W. Moorefield, M.D.
Otto F. Eisenhardt, M.D.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

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Legislation and the Physician

TODAY AS MUCH attention must be focused on the Capitol dome as on the laboratory or university classroom as a source of new developments affecting the practice of physicians in Georgia. Health care delivery has now become the concern of politicians who must become instant experts on the field.

It is unrealistic to assume ideal legislation will emerge from routine committee and floor work if no efforts are made to inform legislators of the position and opinion of the medical profession. Without a determined effort by MAG members to serve as a source of information on measures relating to medicine, legislators will have an unbalanced frame of reference on which to base a decision, influenced by their own limited experiences with medicine or the aggressive lobby of other groups.

Your area legislators may be golfing buddies or no more than a tattered poster on a telephone pole to you. Learn their names—if necessary by contacting the MAG legislative representative Rusty Kidd at 938 Peachtree Street, N.E., Atlanta, Georgia 30309, phone (404) 876-7535 and, after 5:30 p.m., 872-1764. You also can get a copy of a booklet on the members of the General Assembly by writing Ben W. Fortson, Jr., Secretary of State, State Capitol, Atlanta, Georgia 30334.

Let them hear from you regularly because, ultimately, they are politicians whose positions are won and kept through a sensitivity toward and proper response to public opinion. They may come to count on you for the facts they have no other way of getting.

Briefly listed and explained below are items relating to the medical profession which should come before the General Assembly in its term January 8 through mid March.

HEALTH MAINTENENCE ORGANIZATIONS: Contract Practice HMO's are currently being investigated by the Department of Health, Education and Welfare. Public Law 92-603 (H.R. 1) allows payment to be made by Medicare on a pre-payment capitation basis to HMO's.

The Medical Association of Georgia is opposed to the development of contract practice HMO's in Georgia. As an alternative to such organizations, MAG supports the development of Foundation Medical Care Plans.

MAG's Committee on Legislation has reviewed certain principles which it feels organized medicine should support in any enabling legislation for pre-paid comprehensive care organizations.

MEDICAL ADVISORY BOARD: At present the Georgia Department of Public Safety has no structured means of getting medical advice on methods to assess an individual's capability to operate a motor vehicle. MAG has developed a bill which would establish such a Medical Advisory Board of physicians provided by this organization. Members would render appropriate medical judgment concerning the granting, suspension or revocation of driver's licenses to individuals having physical or mental handicaps which may limit their ability to operate a motor vehicle safely.

HYPNOSIS: MAG is in favor of limiting the use of hypnosis of lay people and of forbidding the advertisement of hypnosis in mind control. In our judgment, the

use of these techniques should be limited to licensed psychologists, dentists and physicians.

CERTIFICATE OF NEED: This type of legislation is likely to be introduced again in the upcoming session. In the past these bills have provided that no hospital or related institution can be constructed or expanded unless a certificate of need has been issued by the Department of Health. This type of bill can be expanded to include a certificate of need for professionals in their respective fields. Viewed as a deterrent to free enterprise and individual rights to choose the geographic area in which to practice, such legislation is opposed by MAG.

CHIROPRACTORS AND MEDICAID: MAG opposes the inclusion of chiropractic services in Medicaid as an injudicious use of tax funds and a backward step in efforts to maintain high quality health care for all Georgians.

The U. S. Department of Health, Education and Welfare, the AFL-CIO and the National Council for Senior Citizens are among the many groups which have opposed the inclusion of chiropractic services in government health programs.

MAG is considering introducing legislation in the 1973 Georgia General Assembly to limit the licensure of chiropractics to those who have received a chiropractic degree from an accredited school recognized and approved by the National Commission on Accreditation and the U. S. Office of Education, U. S. Department of Health, Education and Welfare.

The chiropractors, encouraged by their "near win" (missed by only two votes) are certain to introduce their bill again in the 1973 session. This bill would compel all health and accident insurance policies to include reimbursement for chiropractic services.

The Legislative Committee of MAG feels that it is imperative for all members and their associates to assume an aggressive stance in defeating chiropractic legislation and winning passage of the licensure limitations. Success, in addition to the work of MAG employees, takes the efforts of physicians themselves contacting legislators by mail, telephone or personal visit giving the opinion of MAG and the medical profession in the area.

With a willingness to work, joined by the manpower of MAG's legislative Committee and staff, the medical profession can enact or defeat any bill affecting physicians in the state.

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**119TH ANNUAL SESSION OF THE
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AUGUSTA, GEORGIA, MAY 10-13, 1973

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**John McClure, Jr., M.D., Chairman,
MAG Scientific Exhibits Committee**

**Attention: Mrs. Catherine L. Wooten
938 Peachtree Street, N.E., Atlanta, Georgia 30309**



THE CLINICAL IMPORTANCE OF HIS BUNDLE ELECTROGRAMS

JEROME B. BLUMENTHAL, M.D., *Marietta*

THE PAST FIFTEEN YEARS have witnessed a great outpouring of new and exciting insights into the electrophysiology of the heart, both at the cellular and "macro" level. The latter have been largely due to technical advances, namely pacemakers, cardioverters, monitors and intracavitary electrograms.

A technique which came on the scene in 1968 has shed new light on many diverse clinical problems, and though remaining at this time, confined in availability to a few regional centers, has had direct influence on the bedside practice of cardiology. The His bundle Electrogram consists of carefully filtered electrograms obtained from the AV node, bundle of His and Bundle branches via carefully positioned electrode catheters.

The technique will not be discussed here. The following comments highlight some clinical situations where His bundle electrogram data has proven of value.

Localization of the Area of A-V Delay

Atrioventricular conduction can be divided into A-H time, or conduction time from the atrium to the Bundle of His and includes conduction through the A-V node (except when an accessory pathway is present); and H-V time, which encompasses the conduction time through the specialized conduction tissue of the ventricle, the common His Bundle, the right and both branches of the left bundle branch.

Many causes of the A-H conduction delays are functional, *e.g.*, carotid sinus-pressure, drugs, inferior wall infarction with reflex prolongation, though organic disease of the conduction system may be seen as a cause.

H-V prolongation is usually the result of organic involvement of the conducting tissue, as in sclerosis of the cardiac skeleton, bilateral bundle branch fibrosis, anterior infarction with septal involvement.

H-V prolongation in the presence of unilateral bundle branch block suggests disease in the unaffected bundle; when prolonged in the presence of bifascicular block the single remaining pathway is involved.

Atrioventricular Block

PR prolongation can result from delayed conduction at the atrial, A-V nodal, or H-V (Bundle of His-Ventricle) level. When LBBB coexists the disturbance is likely to be diffuse, involving the A-V node and ventricular conduction systems; when RBBB is present the A-V node only is likely to be involved.

Second degree block, when of the Wenkebach type (Type I), is almost exclusively an A-V nodal defect without involvement of the tissue within or below the Bundle of His. Type II (Mobitz) is usually caused by block below the node and often represents bilateral bundle branch involvement.

When fixed ratios of second degree block at 2:1 exist, the block may be Wenkebach or Mobitz. A narrow QRS indicating normal ventricular conduction favors, but is not diagnostic of, Wenkebach. The obvious importance of differentiating the

two lies in propensity to progress to complete heart block and the natural course and response to drugs, should that eventuality occur in each type. Though clues to the exact mechanism may exist clinically, His Bundle electrograms can be diagnostic.

High degrees of A-V block, including complete A-V block has several possible sites of involvement. Chronic disease of the conduction system, caused by, *e.g.*, sclerosis of the cardiac skeleton, or more acute injury as with anteroseptal infarction, results in a slow idioventricular pacemaker and often QRS prolongation. There may be surface EKG evidence of progressive bilateral bundle branch block. This His electrogram shows the P waves to be blocked below the His bundle.

In digitalis intoxication, inferior infarction, and calcification of the mitral ring, the prolongation is in the A-H interval or the P wave is not followed by an H Deflection indicating block in the A-V node. This is usually followed by a faster junctional pacemaker and narrower QRS.

His bundle electrograms have demonstrated that the retrograde P waves are the result of ventriculoatrial conduction through the specialized conduction tissue and the A-V node. Thus ventricular echos are explained by antegrade and retrograde conduction through the A-V node, with functional intranodal dissociation.

Reciprocating tachycardias can result from an impulse descending through the A-V node to the His Bundle simultaneously descending on to the ventricles and ascending to the atria through non-depolarized nodal pathways to re-excite the atria and initiate another cycle. His bundle electrograms have shown that atrium to His bundle time, the time to traverse the A-V node, is normal in classical WPW syndrome. The His to ventricle time is shortened so that the His bundle spike and the QRS are almost simultaneous, confirming another conduction pathway, the bundle of Kent.

In the patient with a short PR interval with normal ventricular conduction, also prone to paroxysmal tachycardia, the Lown-Ganong-Levine Syndrome, the A-H interval is shortened and the usual delay in conduction through the A-V node is not seen. This pathway which bypasses the A-V node is the James bundle.

These are a few of the clinical situations in which His bundle electrograms have elucidated pathophysiological mechanisms and allowed rational therapeutic decisions to follow.

50 Plaza Way 30060

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THE LIABILITIES OF PHYSICIANS RENDERING FIRST AID AT THE SCENE OF AN ACCIDENT

JEFFREY L. RANEY,* *Atlanta*

PHYSICIANS CAN BE of the greatest assistance in providing the proper medical treatment for accident victims. Yet these persons, by reason of their generally good economic status, face the possibilities of malpractice suits as a result of providing such emergency services. The purpose of this article is to review the development of statutory law and case precedent governing the extent of a physician's liability under such circumstances.

While a physician may have a moral and ethical obligation to aid victims at the scene of an accident, the law imposes no affirmative duty to do so. If, however, a physician *does* render aid under such circumstances, common law doctrines impose a legal obligation upon him to use reasonable care in administering such aid. This proposition was aptly summarized by Judge Cardozo when he noted that:

[T]he hand once set to a task may not always be withdrawn with impunity though liability would fail if it had never been applied at all. *H. R. Moch Co. v. Rensselaer Water Co.*, 159 N.E. 896 (1928), at page 898.

Another factor to be considered by a physician under such circumstances is the problem associated with terminating the doctor-patient relationship which may be created by reason of rendering first aid. Under the common law doctrine of abandonment, a physician who leaves a patient in a critical state, without reason or sufficient notice to enable the patient to obtain other medical assistance, may be liable for the resulting damages.

The above-described common law doctrines place a physician desiring to render emergency medical assistance in a potentially compromising position. The physician going to the aid of an accident victim faces the possibilities of being sued if all does not go well for the injured person. The resulting litigation would be time consuming and might damage him both economically and professionally.

While the common law subjects a physician to possible liability, the record under such circumstances does not support the proposition that malpractice suits will inevitably result in adverse judgments. To date, there are virtually no reported appellate cases of malpractice suits against physicians resulting from aid rendered victims at the scene of an accident. Of course, this does not mean that there have been no such suits, since most malpractice cases are settled and, therefore, are not reported. The concern by physicians of possible litigation evolving from first aid assistance is reflected in a survey of some 1,200 doctors taken in the early 1960's which indicated that approximately one-half of them would not render medical aid at the scene of an accident for fear of the resulting liabilities. The above-de-

* Prepared at the request of The Medical Association of Georgia. Mr. Raney is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Council to the Association.

scribed conditions, together with reported cases of injured skiers and automobile accident victims being intentionally ignored by physicians, have prompted numerous state legislatures to enact "Good Samaritan" statutes in order to belay the fears of physicians and encourage the rendering of emergency medical treatment by these persons.

Within the last decade, 44 states, including Georgia, have adopted some form of a Good Samaritan statute. These statutes give qualified persons immunity from liability for damages resulting from services provided in emergency situations. In considering the effect of these statutes upon the common law doctrines described above, several factors must be considered, including the class of persons protected and the emergency situations to which they apply.

Assuming that a Good Samaritan statute meets all constitutional requirements, the question remains as to the operation and effectiveness of such a statute. In answering this question, it is helpful to consider a specific statute and discuss the variations among the other jurisdictions. The Georgia Good Samaritan statute as contained in §84-930 provides that:

Relief from civil liability of practitioners rendering emergency care.—Any person, including those licensed to practice medicine and surgery pursuant to the provisions of this Chapter, and including any person licensed to render service ancillary thereto, who in good faith renders emergency care at the scene of an accident or emergency to the victim or victims thereof without making any charge therefor, shall not be liable for any civil damages as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person.

The Georgia Good Samaritan statute as set forth above applies to all persons rendering emergency care. The class of persons protected under similar statutes in other states varies considerably. For example, some states restrict the immunity to physicians and other medical personnel licensed within the state of the situs of the accident or emergency. In this respect, the Georgia statute is most broad and would encompass any person regardless of his medical qualifications.

The class of persons covered under the Georgia statute are immune when they "in good faith" render the described services. In determining the requirements of this "good faith" test the Georgia statute, like numerous other Good Samaritan statutes, does not specify whether the test is subjective or objective in nature. As a result of the ambiguity of conduct required to invoke the protection afforded under these statutes, the question will, for the most part, remain as a jury question, thus still subjecting the physician to the possibility of litigation. Statutes in other states also qualify this immunity by exempting injuries resulting from gross negligence or wilful and wanton negligence by the person rendering aid.

The Georgia statute further limits the immunity to "emergency care at the scene of an accident or emergency." This wording raises the interesting question of whether emergency care performed within a hospital would fall within this definition so as to deny the hospital patient recovery for malpractice under such circumstances.

The definition of "emergency care" was considered in a recent California case involving the application of that state's Good Samaritan statute. The plaintiff in that case, the victim of an initial automobile accident, was being transported by the defendant to the plaintiff's requested place of destination when the defendant's car was involved in an accident. The court held that the defendant was not administering emergency care since there was no pressing necessity for providing the victim with transportation. As a result, the Good Samaritan immunity was not

available to the defendant. This case illustrates the fact that any care rendered should be limited to that which is deemed necessary by reason of an emergency.

Finally, the Georgia statute provides that the immunity is only available where no charge for the emergency care is made to the victim. This requirement of lack of remuneration would in any event seriously limit the availability of this immunity in the situation where the emergency arises in a hospital.

In summary, "Good Samaritan" statutes enacted by most states still leave the physicians open to potential litigation resulting from administering emergency care at the scene of an accident. Such liability might arise from the fact that this immunity may be available only for good faith efforts or similar standards of conduct and apply only to physicians licensed within the state where the accident occurred or the emergency arose. These qualifications upon the applicability of Good Samaritan statutes somewhat dilute the effectiveness of these statutes in encouraging persons to render first aid. While such statutes have not fully accomplished the legislative purposes, they, coupled with the record of virtually no malpractice judgments under such circumstances, clearly indicate that a physician will not unduly expose himself to litigation by administering emergency care at the scene of an accident.

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SOCIETIES

The **Cobb County Medical Society** has elected new officers for 1973: Donald R. Rooney, M.D., president; J. Gary Palmer, M.D., president-elect; Robert P. Coggins, M.D., secretary-treasurer. Outgoing president is Norman J. Bowles, M.D.

PERSONALS

Fifth District

John T. Galambos of Atlanta received the Seale Harris Award November 15 from the Southern Medical Association at its annual meeting in New Orleans. Dr. Galambos, professor of medicine at Emory University School of Medicine, was honored for his contributions to and research in the field of gastroenterology.

Bernard S. Lipman, Atlanta, has recently had published the sixth edition of *Clinical Scalar Electrocardiography*, a textbook on the subject, by Year Book Medical Publishers, Chicago, Ill. Dr. Lipman is an associate professor of clinical medicine at Emory University School of Medicine and director of heart station, St. Joseph Hospital.

Carlos A. Selmonosky, Atlanta, has been named a Fellow of the American College of Chest Physicians in convocation ceremonies during the College's recent annual Scientific Assembly in Denver, Colo.

Sixth District

Lovick E. Dickey, Macon, was elected 1973 president of the Georgia Orthopaedic Society at its annual meeting November 3-4 in Sea Island. Retiring president is Thomas E. Whitesides, Jr.

Seventh District

Richard W. Cohen, Austell, recently became board certified in orthopaedic surgery following examinations in Chicago, Ill.

Newly-elected vice president of the Georgia Orthopaedic Society is **James M. Kelley** of Rome. The annual meeting at which the election took place was November 3-4 in Sea Island.

Donald W. Schmidt, Cedartown, has been named a fellow in the American Academy of Family Physicians.

DEATHS

Joseph E. Lever

Sandersville physician Joseph E. Lever, 50, died November 13 at his residence.

Dr. Lever had lived in Sandersville 28 years, practicing medicine for 24 years. A World War II veteran, he was serving his second term as National Surgeon General of the Veterans of Foreign Wars and was surgeon general of the Georgia VFW.

Survivors include his widow, Mrs. Mary Louise Lever of Sandersville; parents, Mr. and Mrs. Frank Lever of Sandersville; and sister, Mrs. John H. Brown of Burkley Heights, N.J.

Robert C. Pendergrass

Robert C. Pendergrass, Americus radiologist, died November 11.

A native of Monroe, Dr. Pendergrass was graduated from The Citadel in Charleston, S.C. and Emory University School of Medicine, beginning his practice in Americus two years after graduation.

He was honored with the 1961 Hardman Award for outstanding achievement in the practice of medicine in Georgia. He was a member of the Radiological Society of North America, had served as vice president of the American College of Radiology and director of the Georgia Chapter of the American Cancer Society.

For many years he served as director of the Americus Tumor Clinic of which he was the founder.

Survivors include his sister, Mrs. John V. Cook of Decatur; nieces, Mrs. Larry Christopher of Decatur and Mrs. Dessau Payne of Arlington, Va.; brother-in-law, George R. Ellis, Sr., of Americus.

Jack Guy Standifer

Jack Guy Standifer, 84, died November 20 in Blakely following a long illness.

He was the third generation of Standifers to serve as doctors in the community and the third to graduate from the Medical College of Georgia. He also attended Mercer University and Staunton Military Academy in Virginia.

Professional affiliations included the Southwest Georgia Medical Society of which he was past president, the American Academy of General Practice and the American Association of Railway Surgeons. He served the Central of Georgia Railway as company surgeon for 25 years.

Dr. Standifer was past chairman of the Early County Board of Health, past medical examiner, crime commissioner and county physician and received the General Practitioner of the Year award of MAG in 1960. He was mayor of Blakely in 1953-1954 and member of the board of education.

Survivors include his wife, Mrs. Sarah Rebecca Moore Standifer; daughters, Mrs. T. F. Davis of Athens, Miss Laura Marjorie Standifer of Albany and Mrs. J. L. Meadors of Moultrie.

James Irvin Vansant, Jr.

Villa Rica physician James Irvin Vansant, Jr., died of cancer November 24 at the age of 53.

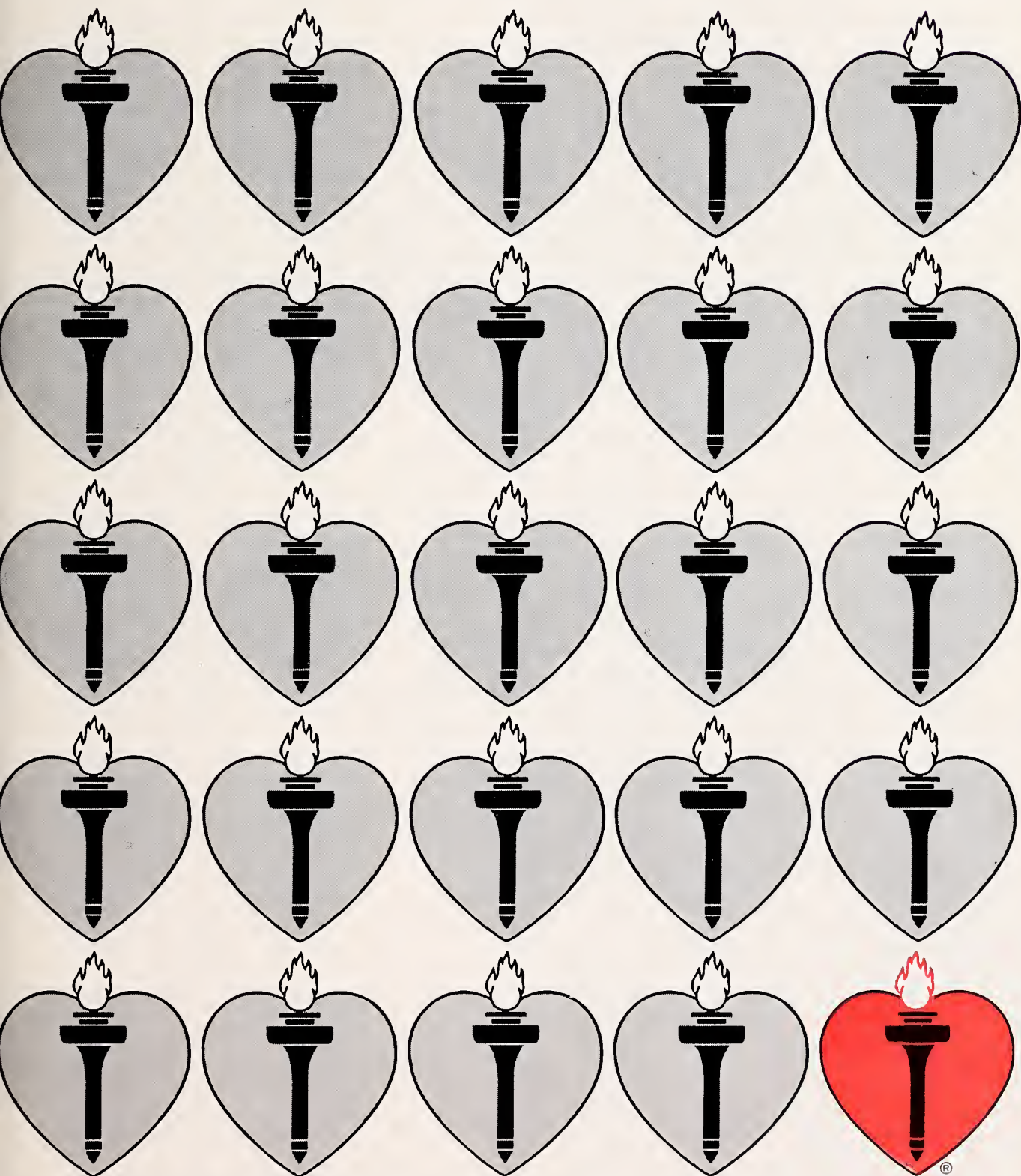
He was educated at West Georgia College and Emory University before being graduated from Emory University School of Medicine in 1951. His internship was served at Crawford W. Long Memorial Hospital in Atlanta.

He is survived by his widow, Mrs. Helen Lackner Vansant; daughter, Mrs. Frank B. Rhodes of Smyrna. Mrs. George K. Mengert of Sandy Springs. Mrs. John S. Rogers of Carrollton. Mrs. Bill D. Craig and Miss Laura Lee Vansant of Villa Rica.

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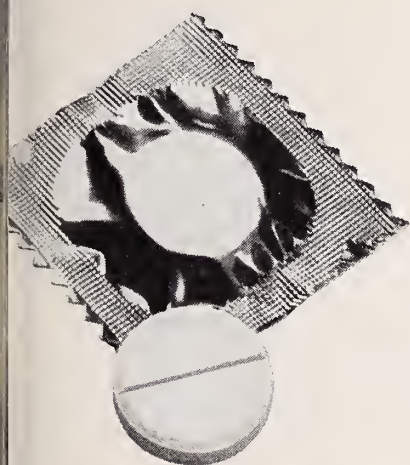
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150 & over	1.5	3

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Pinworm disease	Two doses per day for 1 day. Repeat in 7 days. This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
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Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
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Cover

With a heart for each year of service to Georgia families, the February cover design by Atlanta artist Bob Hamill salutes the Georgia Heart Association on its Silver Anniversary.

he object of this report is to emphasize some aspects of preoperative evaluation of the portal hypertension patient as it relates to the choice of operation.

Selective Decompression of Esophageal Varices—Advantages and Indications

ATEF A. SALAM, M.D., and W. DEAN WARREN, M.D., *Atlanta**

RECENTLY THERE HAVE been significant advances in the techniques of studying hepatic physiology and portal circulation. For many years we have been interested in the clinical application of these techniques to the field of portal hypertension. In previous reports^{6,9} we emphasized the therapeutic implications of the hemodynamic changes characteristic of this disease, and in 1967¹⁰ we described a new approach and a new operative procedure for the surgical management of variceal bleeding.

Clinical Evaluation—The importance of having a complete history and physical cannot be overstated. Most commonly, the history obtained suggests either alcoholic or postnecrotic cirrhosis as the cause of portal hypertension. In the absence of such history, particularly in a patient who has had previous episodes of pancreatitis or intraperitoneal suppuration, thrombosis of the portal vein or the splenic vein should be suspected. Also, there are certain features in the history which influence the decision regarding the indications and the time of the operation. Thus, a patient with alcoholic or nutritional cirrhosis who has completely abstained from alcohol, maintained excellent appetite and strength while working full time has a much more favorable outlook than a patient with postnecrotic cirrhosis with history suggestive of active liver disease.

The presence of severe muscle wasting and weakness is a poor prognostic sign. Peripheral edema and tense ascites not responding to intensive medical treatment usually indicate severe liver damage. On the other hand, an enlarged liver, if not due to acute fatty infiltration, generally indicates a degree of hepatic reserve which is compatible with favor-

able operative result. Hepatic coma is not always a sign of irreversible liver damage. In presence of marked spontaneous portosystemic shunting, an episode of gastrointestinal bleeding may precipitate hepatic coma, yet the patient recovers once the bleeding stops and the blood products within the intestinal lumen evacuated.

Liver Function Tests

There are few simple tests of established value in the assessment of the extent of liver cellular damage as well as the degree of activity of the disease. These include serum bilirubin, serum glutamic, oxalacetic transaminase, prothrombin activity, alkaline phosphatase, bromsulphalein retention tests and protein electrophoresis. Repeated determinations of these values is helpful in preoperative assessment of the disease.

Liver biopsy is usually not needed to establish the diagnosis of liver cirrhosis. However, in the absence of clinical evidence of liver disease, the biopsy helps to distinguish between the other possible causes of portal hypertension. Needle liver biopsy is especially indicated in the preoperative workup of patients whose serum enzyme levels remain elevated. If the biopsy shows numerous acute or chronic inflammatory cells, the active nature of the disease is confirmed. If Mallory bodies are found in addition, surgery is better avoided because of the high operative risks.

Hepatic blood flow may be estimated by injecting 30 microcuries of radioactive gold (AU 198) through a needle into an unobstructed antecubital vein and monitoring the disappearance rate over the temple. The height of the curve is measured at specific times, plotted on semilogarithmic paper and the

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halftime determined. The K value, which is normally $0.29 \pm .05$, represents the proportion of the cardiac output which perfuses the liver in one minute. Three groups of patients could be identified according to the degree of restriction of hepatic blood flow: mild restriction (average K value $0.23 \pm .07$), moderate restriction (average K value $0.19 \pm .05$) and severe restriction (average K value $0.16 \pm .05$). This simple technique can be easily repeated to study the postoperative changes in liver blood flow. The results of this test should be interpreted carefully because some of the isotope is picked up by the bone marrow and by the spleen.

For hepatic vein catheterization a Number 7 catheter with a single hole at its tip is introduced into the basilic vein in the antecubital fossa and advanced to the right side of the heart and the inferior vena cava into a major hepatic vein. The catheter is placed in a wedged position and the wedged hepatic vein pressure (WHV) is obtained. The catheter is then withdrawn into the free hepatic vein and the pressure is recorded (FHV). The latter is subtracted from the wedged hepatic pressure to get the corrected sinusoidal pressure. Once more the catheter is wedged and a wedged hepatic venogram is obtained by injecting 12 cc of 75 per cent Hypaque at the rate of two cc per second. Two films are exposed each second for the first three seconds and one for each second for the following six seconds. Before the catheter is withdrawn, a left renal venogram is obtained to make sure that this vessel is anatomically suitable for a splenorenal shunt.

Hepatic vein catheterization was done in this series with virtually no complications. The operative pre- and post-shunt pressures in the portal vein correlated fairly accurately with the wedged hepatic pressure before and after operation. If portal hypertension is due to a presinusoidal block secondary to Bilharzial fibrosis, or due to prehepatic portal vein obstruction, the wedged hepatic pressure remains normal.

Normally, the contrast material injected in a hepatic wedge leaves the liver via the hepatic vein. In presence of cirrhosis, owing to the reduced rate of blood flow in the intrahepatic branches of the portal vein, some of these branches may be filled with contrast material and the extent of this retrograde filling reflects the degree of restriction of liver portal blood flow. Accordingly, the patients can be classified into four categories: category I shows no filling of the portal vein (Figure 1); category II shows minimal filling of the smaller branches of the portal vein; category III shows an almost stagnant column

of Hypaque in the major intrahepatic branches of the portal vein; and category IV shows complete reversal of flow in the portal vein (Figure 2). We have found this technique to be particularly valuable in comparing the hemodynamic changes before and after different operative procedures.

Operative Pressures

At the time of surgery, the pressure in the free portal vein is measured (FPVT), the vein is then clamped and the pressure obtained on both sides of

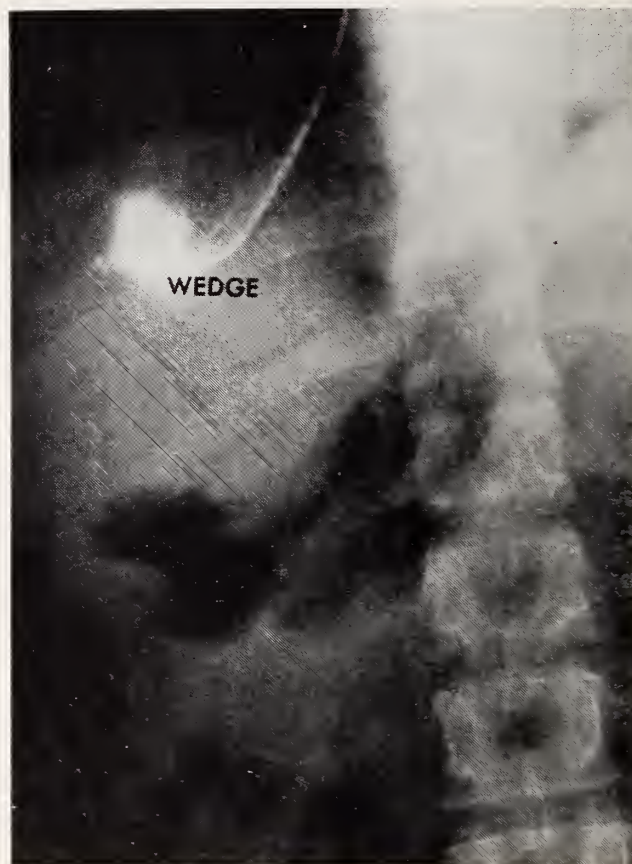


FIGURE 1

Wedge hepatic venogram category I. No opacification of the portal vein or its branches.



FIGURE 2

Hepatic venogram showing retrograde filling of the portal vein (reversal of flow).

the clamp. The pressure on the hepatic side of the clamp is called hepatic occluded portal pressure (HOPP) while the pressure on the intestinal side is called peripheral occluded portal pressure (POPP). There is usually a marked difference between POPP and HOPP in patients who maintain a normal or near normal hepatic portal blood flow. When the operation is done on an emergency basis these pressure measurements are often the only available means to assess the extent of liver perfusion with portal blood.

Splenoportography is the most definitive investigative means in the field of portal hypertension. The procedure is essential before shunt surgery to confirm the availability of the vein for the procedure. It is also a reliable means to assess hepatic portal blood flow. Thus, early and dense opacification of the liver indicates good liver perfusion with portal blood while preferential flow of the dye to the coronary vein and the area of the varices without much of it reaching the liver is a sign of markedly reduced hepatic portal blood flow.

Splenoportography can be done under local anesthesia without much difficulty. The patient is asked to hold his breath and through a small stab incision in the left posterior axillary line in the ninth space, a Teflon catheter threaded on a spinal needle is introduced into the splenic pulp. The needle is then withdrawn and 50 cc of 75 per cent Hypaque are injected at the rate of 10 cc per second and x-ray exposures are made at the rate of two each second for three seconds and then one each second for fifteen seconds. When the study is done as an emergency while the bleeding is being controlled by a Sengstaken tube, the balloons should be deflated, otherwise the findings may be misleading (Figure 3). Splenoportograms can also be obtained indirectly during the venous phase following selective catheterization of the splenic artery the injection of 60 cc of 75 per cent Hypaque at the rate of 8 to 12 cc per second. Indirect splenoportography has the advantage of being safe and easy to repeat following the operation. However, if the spleen is markedly enlarged, or if because of severe atherosclerosis the catheter cannot be advanced far enough in the splenic artery, the concentration of dye on the venous phase may not be sufficient for adequate visualization.

Discussion

The main objective of the surgical treatment of portal hypertension is prevention of recurrence of bleeding from esophageal varices. The remarkable success of portacaval shunt in this regard has led some investigators to advocate the operation as a

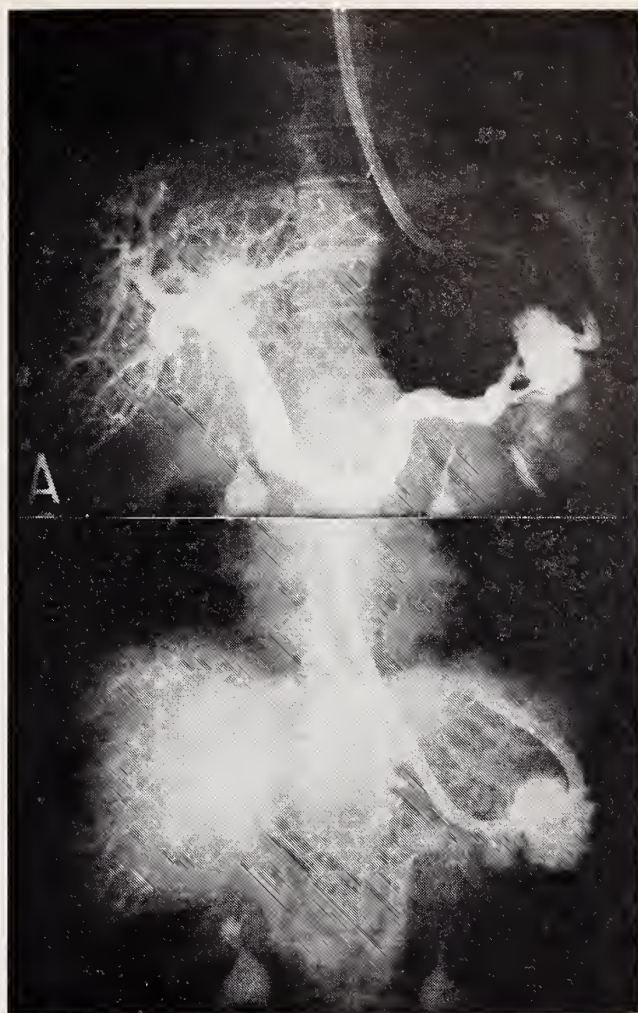


FIGURE 3

Splenoportogram showing no opacification of the varices while balloon tamponade was being used.

prophylactic procedure for the cirrhotic patient with varices. Two recent prospective randomized studies^{2,3} have shown that following portacaval shunt, the overall survival rate is not improved as compared with the control group in which no operation was performed. Careful analysis of the data from these studies reveal that the incidence of hepatic failure in the surgically treated group was considerably higher than in the control group. Such a clear demonstration of the adverse effect of portacaval shunt on the liver has raised serious doubts regarding the therapeutic value of this operation. These doubts have been augmented by reports stressing the high incidence of encephalopathy following the operation. In some studies⁸ some evidence of encephalopathy was present in nearly 60 per cent of the patients who have survived for five years following a portacaval shunt.

For some years we have investigated the hemodynamic changes caused by portacaval shunt and their effect on liver function. We have clearly demonstrated that following the operation, the portal vein fails to perfuse the liver and the portal blood is completely diverted across the shunt to the sys-

temic circulation.⁶ There is experimental evidence¹ indicating that acute deprivation of portal blood results in progressive deterioration in liver function. Therefore, it is reasonable to attribute the increased rate of hepatic failure following portacaval shunt to the total diversion of portal blood which is constantly induced by this operation. This point of view is strongly supported by Mikkelsen's study⁴ in which he found a 60 per cent incidence of fatal hepatic problems following portacaval shunt in patients with idiopathic portal hypertension, most of whom had normal liver function before operation. In view of these problems we advocate a discriminatory approach to the operative treatment of portal hypertension, depending on the extent of hepatic blood flow as determined by the techniques which have already been mentioned. We believe that portacaval shunt should be reserved for the treatment of low flow patients in whom the greater portion of the portal blood volume is already being spontaneously shunted to the systemic circulation. In our experience, such patients tolerate the operation fairly well.

Our approach to patients with high hepatic blood flow has been strongly influenced by the desirability to preserve the liver perfusion with portal blood. At the beginning, we thought that this objective can be achieved by the devascularization procedure as advocated by Womack and Peters^{5,7} at Chapel Hill. Early in our series we became dissatisfied with this operation because of the high incidence of rebleeding. We became interested in developing a new procedure in which selective decompression of the variceal bed is achieved by anastomosing the peripheral (splenic) end of the divided splenic vein to the side of the left renal vein. The central or hepatic end is closed, leaving the superior mesenteric venous drainage flowing to the liver (Figure 4).

An important step of the procedure consists of

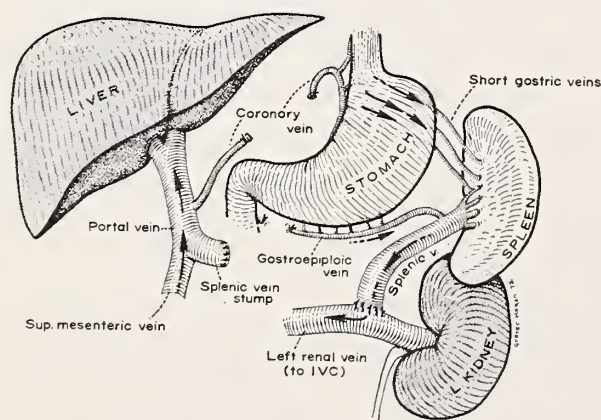


FIGURE 4

Diagrammatic illustration of the distal splenorenal shunt.

ligating the coronary vein at the lesser curvature of the stomach in order to interrupt the flow of portal blood along this vessel to the decompressed variceal bed. This serves the double purpose of increasing the volume of liver perfusion with blood and decreasing the circulatory load in the variceal bed. This operation, which is referred to as the distal splenorenal shunt, should not be confused with the standard splenorenal shunt where the spleen is removed and the central end of the splenic vein anastomosed to the left renal vein, or with the side to side splenorenal shunt where the shunt is constructed between the two veins without interrupting any of them. A unique feature of the distal splenorenal shunt which the other two procedures lack is the preservation of liver perfusion with portal blood (Figures 5 and 6).

Since we described the distal splenorenal shunt in 1967, we have accumulated a series of 40 patients, the great majority of whom were studied before and after operation. The longest period of follow-up is nearly five years and the preliminary results of this study are very encouraging. None of the patients have bled nor has there been any evidence of encephalopathy. There was no need to restrict dietary proteins and the metabolic studies of protein tolerance have shown a markedly diminished eleva-

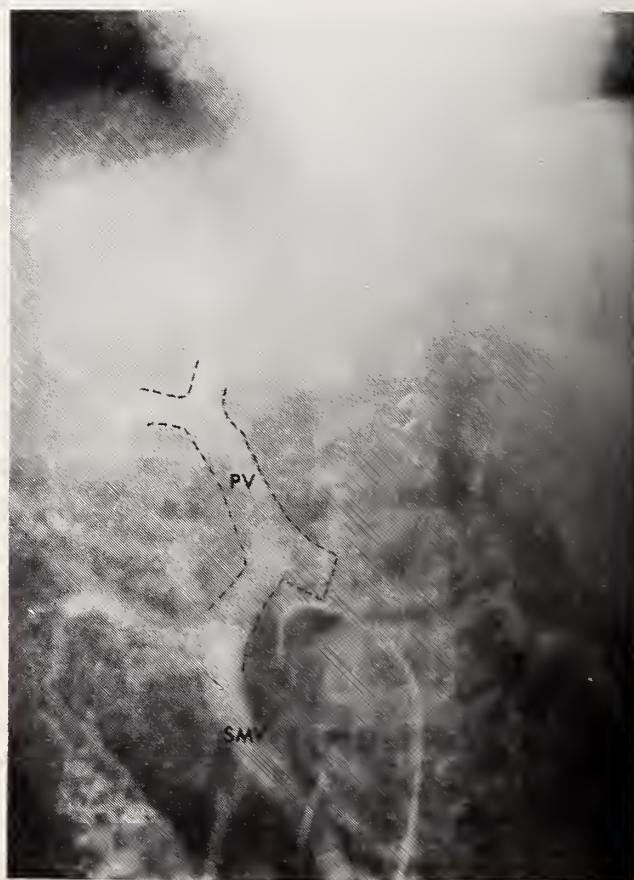


FIGURE 5

Venous phase of superior mesenteric artery injection demonstrating excellent liver perfusion with portal blood following a distal splenorenal shunt.

tion of peripheral blood ammonia when compared with portacaval shunts. The venous phase of splenic artery injection (Figure 7) has shown that the shunt remained patent except in two patients, one of whom had Schistosomiasis and the other had advanced malignant hepatoma. Of great significance is the demonstration of liver perfusion with portal blood on the venous phase of superior mesenteric artery injection, indicating that the theoretical advantages of the operation have been accomplished. Although this procedure is technically demanding, the operative mortality in our series has continued to decline and presently it is in the range of 10 per cent.

Summary

Our experience with the recent techniques of the study of hepatic physiology have been described and patients with portal hypertension have been described. Patients with portal hypertension are classified into two groups: those having marked restriction of hepatic portal blood flow for whom portacaval shunt is the operation of choice; and those



FIGURE 6

Splenoportogram showing failure of liver perfusion with portal blood after a side to side mesorenal shunt.



FIGURE 7

Patency of the distal splenorenal shunt as demonstrated on the venous phase of splenic artery injection.

who have high hepatic portal blood flow who are best treated with selective decompression of their varices while maintaining the liver perfusion with portal blood. The distal splenorenal shunt is a new operative procedure which seems to meet this qualification. Presently, we are conducting a prospective randomized study to investigate the advantages of this procedure in terms of prolongation of life.

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DOCUMENTARY EVIDENCE NEEDED

Physicians run the risk of being subjected to retroactive denial of Medicare benefits unless they are able to provide acceptable documentary evidence substantiating dates of their hospital visits, the AMA warns. As a precautionary measure, the AMA urges physicians to "make sure that there is an entry on the hospital record for each patient substantiating the date of each visit."

To guide physicians, the AMA has developed an informational statement based on Medicare rules and verified by the Bureau of Health Insurance. Write the Division of Medical Practice, AMA, 535 North Dearborn Street, Chicago, Ill. 60610.

Challenging Aspects of Adolescent Medicine

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THE FRONTIERS of the pediatric specialty have, in recent years, expanded into two new directions: the first to the pre-natal life, Neonatology, which goes into the fields of obstetrics and gynecology, and the other, adolescent medicine, using knowledge from internal medicine and psychology.

The adolescent, the child from 12 to 18 years, has been until recently a medically neglected individual, too old for the pediatrician, too young for the internist. On the other hand, the medical problems proper of this age have grown in complexity especially in regards to sexual development and behavior, contraception, pregnancy, abortion, venereal disease and drug abuse. This paper attempts to present a panoramic review of these topics from the point of view of a pediatrician with special interest in adolescent medicine.

Adolescent medicine began to be defined as a distinct branch of pediatrics, thanks to the pioneer work of Dr. Roswell Gallagher who, in the early 1960's, opened the first strictly-adolescent outpatient clinic at The Children's Hospital in Boston, Mass. Moreover, his classic textbook, *The Medical Care of the Adolescent*, motivated many pediatricians to seek additional knowledge and skills in dealing with adolescents.

In the last 20 years the medical care of the adolescent has been influenced upon by social factors such as rapidly changing moral values; less parental control and guidance; more permissive attitudes toward sex; the seeking of instant gratification through drug abuse; and the alarming increase in the incidence of V.D. These, without doubt, are some of the most pressing problems of today's youth and consequently the concern of pediatricians.

There are today, scattered around the country, excellent adolescent units which offer comprehensive

out-patient care as well as opportunity for education of future practitioners of the new subspecialty. However, "the best ground for training in this field is to be found in the office practice of pediatrics, provided that the physician has the time and inclination to become involved with adolescents and their problems."¹

The Doctor and His Patient

Gallagher² early in his work perceived that adolescents are different: "We should think of them in different terms than of a little child or an adult. So, too, is the doctor's relationship to these patients different; no longer is it the parent who tells the story, and now the patient requires very considerable evidence of his doctor's interest in him. How to talk to these young people (or better how to get them to talk to you), how to deal with them effectively, how to utilize, for their own good, their tendency to accept advice from and to initiate and talk freely to other adults than their parents."

Also, the physician dealing with adolescents has to keep in mind some basic principles to make his job a successful one. As pointed out by C. R. Riggs,³ "The personality of the physician and his philosophy of the medical care of his patients is considered to be most important in the medical care of adolescents. He should be mature and open-minded. He should be genuinely interested in teenagers as persons first, then their problems and also their parents. He should not only like teenagers but must also feel at ease with them. He should be able to communicate with his patients and their parents."

The Patient's Parents

The pediatrician or general practitioner undertaking the task of giving comprehensive medical care to adolescents has to educate parents in particular and the community in general.

The idea that pediatricians are "baby doctors" is

* Paper was read in part at the Seventh District Medical Meeting at Alatoona Lake, Georgia, Sept. 27, 1972. Dr. Montana is a practicing pediatrician in Rome and chairman of the Committee on Youth, Georgia Chapter, American Academy of Pediatrics.

still a widespread one among the public. The pediatrician wishing to limit his practice up to a certain age limit should inform parents of his decision and arrange a proper referral to assure that the pre-teen or teenage child is not medically neglected. On the other hand, if his interest goes far and beyond the adolescent years* he should also make his services known to parents. An example of how this can be done is the approach used by Drs. Wessell and La Camera⁴ from New Haven, Conn. They send a letter to the family when one of the members is reaching puberty. I find their letter interesting enough to be quoted:

"Dear Mr. and Mrs. Smith:

"As youngsters enter adolescence we find it beneficial to set aside special time for a conference with parents. We like to follow this with an individual conference with our young patient. This provides an opportunity to be of service to parents and children during the years of rapid physical and psychological growth. This is the time when guidance and understanding are most important.

"We hope that you will call for an appointment before we see your son John for his annual visit next month."

Proper Environment

A relaxed, sympathetic attitude on the part of the pediatrician and his staff is of paramount importance. Proper office decoration and facilities are also important. For example, teenagers should be provided with a separate waiting area preferably with a private entrance. Many teenagers don't like to share a waiting room with screaming babies.

The examining rooms should also be properly equipped. The typical pediatric examining table should be replaced by an adult type with supports for the legs for pelvic examinations.

Communicating with adolescent patients requires adjustment on the part of the pediatrician since he is used to primarily communicating with the parents about the child. Now that the child is becoming an adult he will have to communicate directly with him.

Relaxed manners and a sympathetic attitude on the part of the examining physician will result in good rapport or, as Riggs³ put it, will result in "that one to one relationship that forms one of the most

important contrasts between the practice of adolescent medicine and general pediatrics."

In initiating an interview with an adolescent patient it should be made clear to him that the conversation with the doctor is confidential in nature. A reassurance such as, "Whatever we talk about here is between you and me. We won't tell your parents anything unless we both agree on what to talk about with them," shows the adolescent that the doctor accepts his concerns with respect.

The much talked about "communication gap" should and can be closed by honest dialogue. Many adolescents and their parents have difficulties in communicating among themselves. The physician may well be the first adult the child feels able to communicate with for months or even years.

During the questioning and examination, as Gallagher² advises, "Listen actively. A smile at the wrong moment, a flippant remark, or any suggestion of teasing or condescension may convey the impression that the patient's concerns are unimportant."

Examination of adolescent boys should always be carried out in private. Often, in examining for the presence of a hernia, for example, the child may express his concern about the size of his genitalia, a question which he would not ask if a nurse is present. The same may be true in the case of gynecomastia. Examination of adolescent girls should always be done when a female chaperon is present. Every examining procedure, especially a vaginal examination, if one is to be done, should be explained for reassurance.

Sexual Maturation

In assessing the sexual maturation of a child, chronological age alone is inadequate. As pointed out by Reiter,⁵ "The menarchial age has been falling since the mid-nineteenth century with an acceleration of approximately 4 months per decade between 1830 and 1960." This change is more likely "related to socioeconomic factors such as improved nutrition."⁶

The sequential changes of puberty should be understood and explained to the patient and his parents. A grading system for these changes and the median ages at which they appear has been developed by Marshall and Tanner.^{7, 8} The reader is referred to their articles for detailed charts. From a practical point of view one should remember that in girls, the first sign of the advent of puberty is usually the development of nipple buds, then pubic hair, areolar pigmentation, axillary hair and then the physiologic mucoid vaginal discharge present for about six months before the first period. In boys, puberty is heralded by the presence of pubic hair and enlargement of the genitalia.

* The new definition of pediatrics prepared by the American Academy of Pediatrics, Council on Child Health and approved by the Executive Committee, supersedes the previous definition used since 1938 and says: "The purview of pediatrics includes the growth, development and health of the child and therefore begins in the period prior to birth when conception is apparent. It continues through childhood and adolescence when the growth and developmental processes are generally completed and usually terminates by 18 years of age." Newsletter, A.A.P., Vol. 22, No. 18, Dec. 1, 1971.

It should also be remembered that the events of puberty occur about two years earlier in girls than in boys.

Along with the maturation of their sexual and reproductive capabilities, adolescents, boys and girls alike, develop a tremendous concern about their physical appearance. A girl may suffer if her breast is too small or too big. A boy may develop a "locker room complex" if he thinks that his penis is too small.

The physical changes mentioned above also bring about the emotional upheaval proper of adolescence with a desire for independence, self identity and scrutiny of adult moral standards.

In dealing with sexual matters the physician treating adolescents often has to eliminate his own hang-ups and misconceptions and often has to re-examine his own attitudes and system of values. In a changing culture "he must understand the impact of growth and development in order to respond to questions of adolescents about their sexual identities and the ensuing emotional implications."⁹

Since sexual education begins at home, parents and teachers alike must be made to realize that the impact of adolescence may reach a boy or a girl at a time when he or she is not emotionally equipped to deal with the responsibilities of the newly developing sexuality.

With these considerations in mind the physician should try to establish a *meaningful dialogue*, instead of a lecture, in discussing the problems arising from search of sexual identity such as masturbation, homosexuality, contraception, premarital intercourse and the like.

Premarital Teenage Intercourse

An analysis of significant studies such as Kinsey's,¹¹ on sexual behavior and Reiss¹² on sexual standards as well as conversations with adolescent girls and boys have convinced the author that the abused cliché of "sexual revolution" is, contrary to popular belief, not one of more sexual premarital activity, but one of franker talk and greater openness about sex.

As it was recently pointed out by Morgenthau and Sokoloff:¹³ "The impression that premarital sex has been on the increase among teenagers, particularly during the past decade, cannot be verified one way or the other, since the evidence is in fact lacking. The only reliable data available, consistently and emphatically, supports the finding that 50 per cent of contemporary American women in their late teens are engaging in premarital sexual intercourse." And,

as Gagno and Simon¹⁴ clearly expressed, "people are still claiming that the sexual revolution is just now in progress even though all evidence points to the fact that the major change in premarital sexual behavior has long since taken place—in the 1920's."

The fact is that today's teenagers (and many adults), have an entirely new attitude which is now just "catching up" with early changes in behavior. Today more people are likely to believe that, under certain conditions, premarital intercourse is permissible and even desirable.

Recent popular literature is also recognized that in fact, today's adolescents are not more "promiscuous" but rather more open about sex and more likely to engage in a stable outgoing relationship in which sex is simply part of that relationship. A recent *Time Magazine* essay¹⁵ dealing with sexual attitudes of today's teenagers quotes the words of a 25-year-old girl talking about her sister just three years younger: "Pat," said the older sister, "had at 15 as healthy an attitude as I wish mine could have been at 18. She and her friends are more open. They are not blasé; they do not talk about sex as they would about what they are going to have for dinner. But they do discuss it, there is no hemming and hawing about it. And boys don't exploit them. With Pat and her boy friends, sex isn't a motivating factor. It is not like the pressure that builds when sex is denied and you feel guilty about it."

In helping adolescents to solve their sexual problems the physician should try to communicate the feeling that sexuality encompasses the entire spectrum of human behavior, the need to belong, to love and be loved, the establishment of meaningful human relationships with respect for self and others. It is the job of the pediatrician "to help teenagers to help themselves to become physically healthy, emotionally mature, socially adjusted adults."¹⁶

Birth Control Education

Although, as we mentioned before, an increase in the percentage of sexually active teenagers cannot be documented, the fact that girls are maturing early and an overall increase in teenage population (in 1969 there were 18.6 million youths aged 15 to 19 in the United States representing 9.1 per cent of the total population¹⁷) has resulted in an evident increase in teenage pregnancies.

Physicians and parents confronted with the reality that the teenager is sexually active are being more and more approached in regards to birth control education.

As pointed out by Marinoff,¹⁸ "Major changes with regards to the provision of contraceptive services to teenagers have occurred over the past few

years. The end of the 60's saw physicians struggling with moral and ethical problems. However, faced with the rise of teenage pregnancies, the trend went from *whether* to provide birth control to *how*."

The American Academy of Pediatrics, in a recent statement, April, 1971, recommended that, "the teenage girl whose sexual behavior exposes her to possible conception should have access to medical consultation and to the most effective contraceptive advice and methods consistent with her physical and emotional needs; the physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his best medical judgment in the best interest of his patient."

However, the legal implications of prescribing contraceptives to minors were not clear, at least in the state of Georgia, until the 1972 Session of the General Assembly. In fact, Georgia physicians may not be aware that the new Family Planning Services Act, No. 1224, amending section 88-2904 reads: "as to provide that any female, regardless of age or marital status, may give consent to medical or surgical treatment for herself when given in connection with the prevention of pregnancy" (effective July 1, 1972). Also, the law in Georgia allows minors to consent for examination and treatment of V.D. without notification of parents.

The choice of contraceptives implies, on the part of the physician, a complete knowledge of his patient. Knowledge involving not only her physical but her emotional conditions and factors such as frequency and conditions around intercourse. Methods such as the diaphragm or rhythm should be considered only for married women. The irregularity of the teenage cycle, for example, and the lack of knowledge about ovulation exhibited by teenagers precludes these methods for them.

In Marinoff's¹⁸ opinion, "for the teenage population the condom is still the most easily available and cheaper form of contraception." In this regard, the findings from a study in a inner city area in North Carolina¹⁹ in which condoms were distributed free through commercial outlets such as grocery stores, barber shops, and pool halls revealed that: 1. Condoms were acceptable to adolescents in a magnitude not previously appreciated. 2. Adolescent males accepted the sizable share of the burden in pregnancy prevention when given the opportunity. 3. Small neighborhood commercial outlets were found to have a potentially important role in non-clinical contraceptive distribution programs."

When oral contraceptives are prescribed to teenagers there is always the risk of high failure associated with discontinuance. Also, the difficulties from hiding the pill from uninformed parents may pro-

duce anxiety and guilty feelings to add to the possible side effects.

The Pregnant Teenager

As it has been implied before, when the pediatrician has grown with his patient and has seen her develop into a teenager, he may be in an advantageous position to help that girl in the event of an unwanted pregnancy.

A significant contribution to the understanding of the problem is the book by H. J. Osofsky, *The Pregnant Teenager*. He starts on the premise that adolescence is an awkward period of one's life and pregnancy is, at least, an added burden. A pregnant teenager becomes severely handicapped and deprived physically, psychoemotionally, socially and educationally. Thus, she becomes a high-risk patient. Many of these outcast girls do not receive proper medical care and guidance. As is often the case, the pregnant teenager is asked to leave school and interrupt her education. Osofsky²⁰ asks, Why? and lists several misconceptions about this destroying them one by one. His book should be read by every individual engaged in the medical care of adolescents.

It has been estimated that with the new liberal laws on abortion nearly half a million unwanted pregnancies are terminated each year in the United States, many of them in teenage mothers.

The decision as to what to do with an unwanted conception is one that the girl has to face with her parents and "her doctor" which in some cases is the pediatrician. The advice a doctor gives is, to no doubt, influenced by his own background and religious upbringing. In the author's mind, it is unfair to the pregnant teenager, to the unborn child, and to society, to ask her to deliver when she is not physically, emotionally, or financially prepared to care for the baby.

However, every possibility should be exhaustively considered before abortion. The girl facing an unplanned pregnancy should be made aware of the fact that there is indeed another choice. That, for every girl who is telling herself or being told that she does not want to bring a child into the world, there is at least one family, and probably many more, who would dearly love to adopt that child and give it the chance to fulfill its destiny.

Venereal Disease Among Adolescents

As stated recently by Dr. Andrew H. Rudolph,²¹ Assistant Chief of the V.D. Center for Disease Control in Atlanta, Georgia, "Gonorrhea is our number one medical, social and moral problem among adolescents; reported cases of G.C. have shown an increase for 12 of the last 13 years and, for the past

several years the rate of increase has exceeded 15 per cent per year."

In the past three years V.D. has increased 300 per cent!—216,476 cases reported in 1967 against 643,371 cases reported in fiscal 1971.

Some authors blame the increased rate of V.D. on the before mentioned changing moral standards and/or the availability of "the pill." The fact is that gonorrhea rates began soaring up in 1957, a good seven or eight years before the first oral contraceptive.

In the author's opinion, teenagers are still quite ignorant about V.D. Many youngsters may unknowingly suffer symptoms for several days before seeking medical attention. This is particularly true in girls in whom the symptoms of gonorrhea may go unnoticed for several days, thus becoming asymptomatic carriers of infection.

There is no doubt that V.D. and unplanned pregnancy represent the greatest health and social problems confronting adolescents in the 70's, both amenable to prevention by means of education. However, the physician's talks in front of high school or P.T.A. audiences, in the opinion of the author, are of little value.

Novel approaches more appealing to young audiences are urgently needed. A milestone in regards to youth education was the recent Dick Cavett (ABC) Show, *V.D. Blues*, which was first aired on Monday night, October 9, on the Nation's Public Broadcasting Network (PBS). Following is a quotation from the script of Cavett's introduction to a closed-circuit preview of *V.D. Blues*: "Anyway, the young still seem to get their sex education from their peer group—and it's bad education, at least about V.D. So we set out to broadcast some straight information. The target audience of this show is young. Younger than some of you would like to admit. Most V.D. and the fastest rising rate of V.D. is among teenagers. . . . You reach the young by being cool, not by moralizing, by telling them the facts and even by poking fun at the most esteemed stereotypes of their elders. You reach the young through music—rock and ballads that tell an honest story."

To some of the reviewers of the Cavett Show,²² "*V.D. Blues* set out to be an educational entertainment, a sort of *Sesame Street* for the sexually active young." This type of educational endeavors challenge the ingenuity and creativity of the concerned physician.

As it has been profusely written, drug abuse is no longer confined to the ghetto or unprivileged populations. It has extended into every social class and clearly it is reaching children at earlier ages than before.

At a variable time between the ages of 12 and 18 years, every child will have to decide whether or not to use drugs. And, in most cases their parents won't even know that a decision was made.

The high school student, as the author found in a recent local project²³ is mainly an experimenter. Experimentation is, in fact, the reason why many pre-teenage children take that first puff or pop that first pill.

A recent study from the American Academy of Pediatrics listed the following as motivations for drug abuse among adolescents:

1. To try to prove their courage by indulging in risk taking.
2. To act out of rebellion and hostility toward society.
3. To facilitate sexual desire and performance.
4. To relieve loneliness, and provide emotional experience.
5. To attempt to find the meaningful life.

New patterns of drug abuse include the indiscriminate popping of pills of all kinds, the poly-drug usage more prevalent among pre-teenagers today.

As we have mentioned before, the adolescent, per se, is an individual in deep conflict with himself. He is under the anguish of finding his own place in the family and in society. Although it is normal for the adolescent to experiment, he may wrongly assume that the most direct route to find himself is by collecting every new experience.

Experimentation and habitual use of marijuana are difficult subjects to discuss with the adolescent. The youngster will usually respect the doctor's opinion about other drugs such as barbiturates, amphetamines or heroin. Not so about marijuana of which many students possess more knowledge than doctors.

Depending on the population under study, it seems that from one third to three fourths of college students have tried it at least once. And, even those who have already decided not to experiment with "grass" allude to it as an example of hypocrisy and injustice of the adult establishment. In this respect, the American Academy of Pediatrics was pronounced in favor of *decriminalization*, not *legalization*, of marijuana. The physician dealing with adolescents on the question of marijuana will need to be objective and factual and, the fact is that we still don't know about the long term effects of the use of Cannabis.

The author's premise²⁴ in discussing drugs with adolescents is that "youngsters are tired of being talked to; they want to talk with somebody who'll listen to them and help them to find honest answers to their questions. The adults involved in dialogue with adolescents should avoid appearing as experts. We are to be reminded that we, ourselves, have the obligation to become more and more informed about the problems of youth; that we, ourselves, may have emotional hang-ups, misconceptions, or partial knowledge."

In Conclusion

The medical care of the adolescent, due to the peculiar biological and emotional changes taking place from the 12th to the 18th birthday represent a real challenge for the physician involved.

The adolescent's search for self-identity and independence often clashes with adult standards especially in regards to sex. Changing sexual attitudes should make the physician re-examine his own.

A very real alarming increase in V.D. and teenage pregnancy should make doctors re-examine traditional methods of public education and initiate new approaches.

Lastly, in discussing sex, V.D., or drugs, the physician should remember that *honest, informative, factual dialogue* is the most important clinical tool for doctors dealing with adolescents.

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HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

January 14, 1973

MAG Benevolent Foundation: Requested legal counsel to investigate legality of making Trustees a committee of MAG to avoid tax liability on undistributed funds.

Mental Health Committee: Received report of Mental Health Committee dealing with proposed legislation and concern over apparent direction the Division of Mental Health is taking.

Newborn Insurance: Received report from Georgia Academy of Pediatrics urging MAG support for compulsory insurance coverage of newborn from birth.

Statement on Death: Approved use of AMA statement defining death.

Appointments: Joseph S. Wilson, M.D., Atlanta, Chairman Ad Hoc Committee on Geriatric Medicine. Nominated L. C. Buchanan, M.D., Decatur; J. Dan Bateman, M.D., Albany; Frank Wilson, M.D., Atlanta to Title XIX Medicaid Advisory Committee.

GRMP Appropriations: Reviewed telegram from RMP in Washington which indicated possibility of serious reduction in funding.

Next Meeting: Sheraton-Olympic Inn, Atlanta, February 10-11.

This drug prevents spontaneous firing produced by sodium oxalate or phosphate, which may simulate the "spontaneous attack" state of tic douloureux.

The Effect of an Iminostilbene Derivative (G32883) on Peripheral Nerves

HARUYOSHI HONDA, M.D. and MARSHALL B. ALLEN, M.D., Augusta*

PENFIELD POSTULATED that the paroxysmal features of trigeminal neuralgia and Meniere's disease, as well as the lancinating pain of neurosyphilis, were postulated to represent peripheral epileptiform discharges which might be amenable to anticonvulsant therapy by discussing an intriguing paper by Caverness and co-workers in 1949.²

The use of anticonvulsant drugs, especially diphenylhydantoin sodium (Dilantin®) has been advocated for the alleviation of tic pain on the basis of clinical observations and experimental studies.³⁻⁵

According to Toman, Korey and Morrell, Dilantin reduced the excitability of nerves previously rendered hyperexcitable by sodium phosphate or sodium oxalate.

The success of one anticonvulsant medication in the treatment of tic pain prompted clinical trials of a new anticonvulsant, carbamazepine, an iminostilbene derivative (G32883).

In 1962, he⁸ reported consistent success in the control of trigeminal neuralgia with carbamazepine. This report has been confirmed by reports of many series of patients treated for tic douloureux with carbamazepine from Europe as well as the U.S.A.⁹⁻¹⁴

Soulairac, and Charpentier¹⁵ (1964) and Charpentier¹⁶ (1966) concluded from their electrophysiological and neurobehavioral studies that carbamazepine has specific effects on trigeminal pain.

R. Hernandez-Peon¹⁷ found that the drug produced a significant depression of the trigeminal evoked potentials recorded from the bulbar level.

The neurophysiological mechanism underlying trigeminal neuralgia is still obscure.

Gardner²³ and Kerr suggested peripheral origin of trigeminal neuralgia. Short circuiting of impulses may occur when degenerated touch fiber (α fiber)

approximate each other with unmyelinated pain fibers (δ fibers or C fiber).

Stimulated by the reports of clinical success, using carbamazepine, experiments were performed in an attempt to elucidate the neurophysiological effects of carbamazepine.

Material and Method

Ninety-one rats (Holtzman and Sprague-Dawley strains) weighing 200-300 gm. were used in the present studies. Rats received multiple injections of carbamazepine in water, in various dosages, 4 mg./kg. a day to 400 mg./kg. a day (Table 1).

Twenty-seven rats were treated with diphenylhydantoin in a similar fashion.

Under ether anesthesia, the sciatic and posterior tibial nerves were removed. Nerve stimulation studies were performed in a thermostatic conduction chamber.

Using a Tektronix oscilloscope, tracings of the action potential (A.P.) were photographed on Polaroid® film at 4.5, 3.5, 2.5, 2.0 and 1.5 cm. from the point of stimulation. Both inflection and peak velocities were determined.

The inflection velocity is the distance between the stimulating and recording cathode divided by the latent period between the time of stimulation and initial deflection of the A.P. complex. The peak velocity indicates the distance between the stimulating and recording cathodes divided by the latent period between stimulation artifact and the time the peak of the A.P.

Thresholds were measured on each nerve prior to nerve conduction studies.

Tetanic stimuli were given in order to produce prolonged hyperexcitability.

The effect of chemicals on the sodium phosphated or sodium oxalated nerves which will decrease threshold and produce hyperexcitability state of peripheral nerves were studied.

* Division of Neurosurgery, Medical College of Georgia, Augusta. Presented at the 118th Annual Session of the Medical Association of Georgia, May 11-14, 1972 in Macon.

TABLE 1
ANTIEPILEPTIC DRUGS DOSE SCHEDULE

Group	Nerves/ Rats	(Carbamazepine)					Tegretol* Soak	(Diphenylhydantoin)					Dilantin Soak	Sacrifice
		1	2	3	4	5		1	2	3	4	5		
Normal	21/12												
V	11/6	4				15 min. in Tegretol A in situ							4-8 hours after last dose of Tegretol when blood level high
W	9/5	4	8			15 min. in Tegretol B in situ							
X	9/5	4	8	12		15 min. in Tegretol C in situ							
Y	10/5	4	8	12	16	15 min. in Tegretol D in situ							
Z	10/5	4	8	12	16	15 min. in Tegretol E in situ							
1-A	14/7						10	10	10	10	10	10	5 hours after intraperitoneal Dilantin
1-B	14/7						125	125	125	125	125	125	
1-C	21/11												0.05 mEq./L. Dilantin soaks
2-A	16/8	20	20	20	20								
2-B	19/10	50	50	50	50								
2-C	15/8	400	400	400	400								4-8 hours after last dose of Tegretol
U	2/1		12	16									
T	1/1					15 min. in Tegretol B in situ							
Total	172/91												

* A = 20 mg./100 cc. of lactated Ringer, B = 40 mg./100 cc. of lactated Ringer, C = 60 mg./100 cc., D = 80 mg./100 cc., E = 100 mg./100 cc.

The area below A.P. curve was calculated by planimeter.

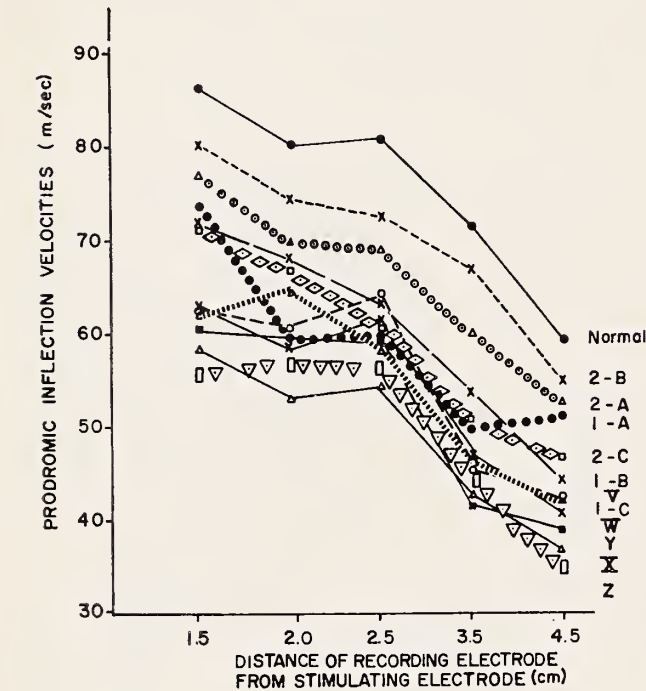
Results

A total of 172 sciatic nerves of rats were examined for the purpose of determining the effects of carbamazepine and dilantin. Carbamazepine will:

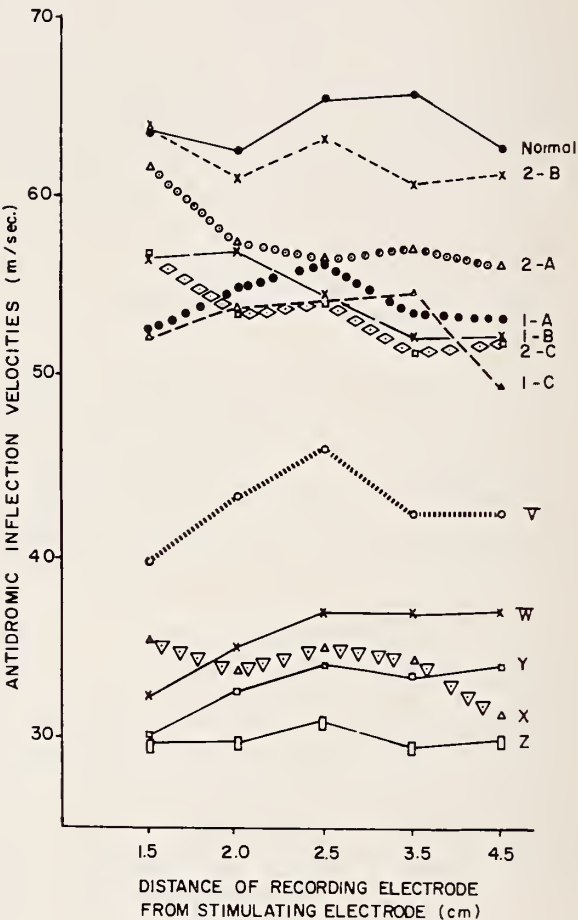
(1) Increase the threshold of a nerve to electrical stimulation.

(2) Decrease conduction velocity of fast as well as slow conducting A fibers both orthodromically as well as antidromically (Graphs 1-4).

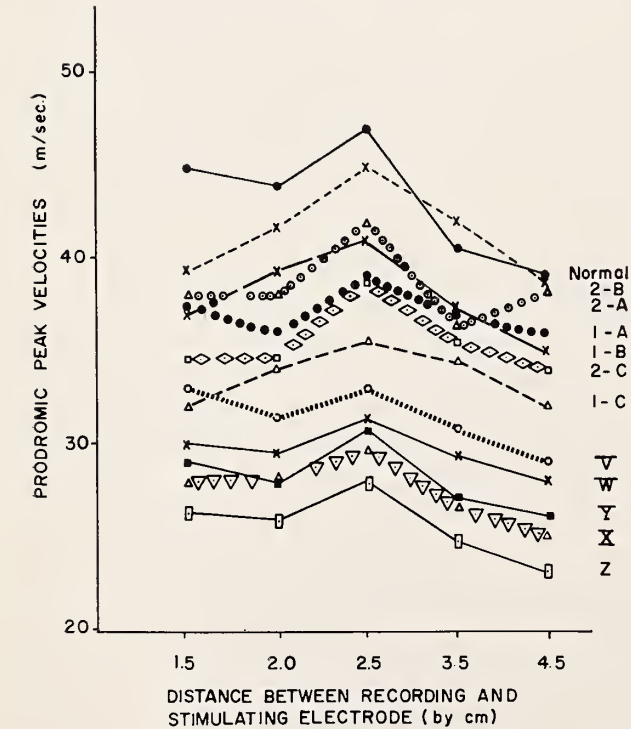
(3) Decrease A.P. height and area with increas-



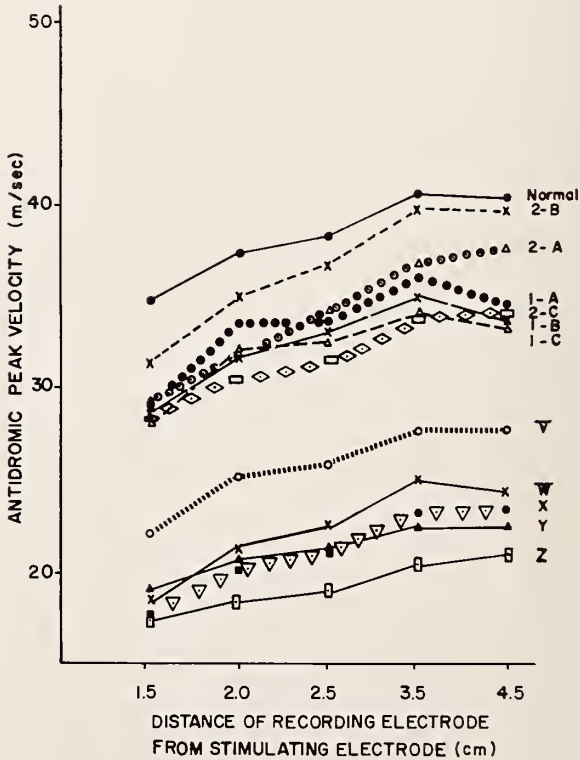
GRAPH 1



GRAPH 3



GRAPH 2



GRAPH 4

ing doses of carbamazepine up to the point of complete block (Table 2).

(4) Diminish or terminate the hyperexcitable state produced by tetanic stimuli.

(5) Block Delta fiber A.P.s while slowing of alpha fibers conduction in 10 to 15 minutes and finally block α fibers. The A.P.s will return after the nerve is washed with Lactated Ringer solution (Figure 1).

(6) Diminished hyperexcitability produced by immersion in isotonic sodium oxalate or phosphate one hour or two hours (Figure 2).

(7) The present study confirms similar alterations of peripheral nerve responses after dilantin administration.

Discussion

Morrell⁵ reported that dilantin increased conduction time of peripheral nerves.

Our studies confirmed these findings. Intraperitoneal carbamazepine slowed the conduction time of A fiber potentials when animals were given 12 mg./kg. per day for two days. However, by increasing the dose of carbamazepine and by administering the drug for prolonged periods, the retardation of

conduction velocities was not significantly increased. The nerves treated with intraperitoneal injections of carbamazepine associated with soaking showed progressive slowing with increasing doses.

King and Meayher studied trigeminal potentials in cats after stimulation peripherally and after section of the sensory root and the spinal trigeminal tract. Their work suggests that the stimulation of large touch and pressure fibers (A fibers) in the peripheral trigeminal system activates delayed response of small fibers (C fibers) in the spinal trigeminal system. The delayed response can be reduced by blocking the rapidly conducting fibers in the stimulated tactile or proprioceptive fibers.

The α among A fibers are myelinated and fast

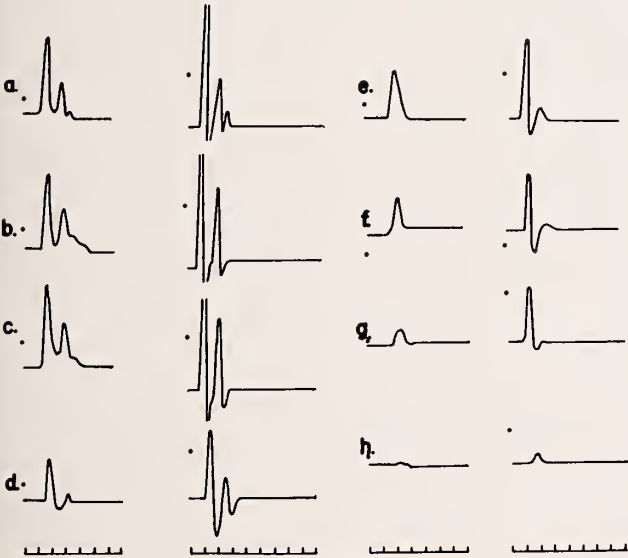


FIGURE 1

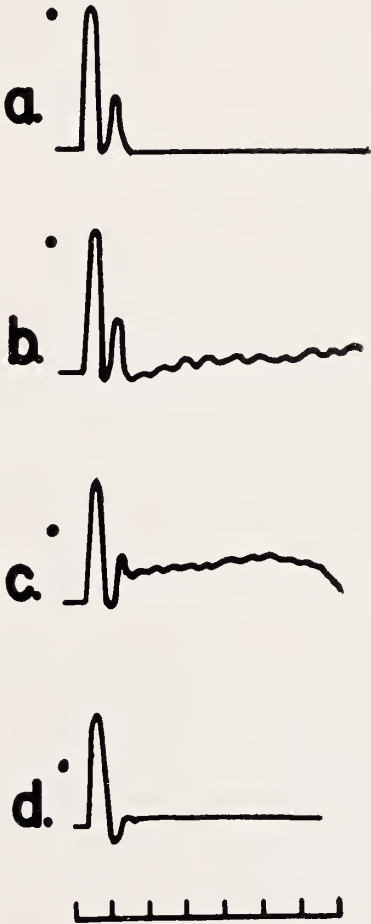


FIGURE 2

TABLE 2
ACTION POTENTIALS (A.P.) HEIGHT AND AREA RATIO

Distance	1.5 cm.		2.0 cm.		2.5 cm.		3.5 cm.		4.5 cm.	
	A.P.		A.P.		A.P.		A.P.		A.P.	
Group	Height	Area	Height	Area	Height	Area	Height	Area	Height	Area
Normal ..	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
V	48.7	56.6	58.1	73.3	50.4	49.2	47.6	64.5	57.1	54.8
W	37.6	59.0	41.1	53.3	43.6	55.0	39.0	47.9	49.4	50.8
X	42.1	61.5	51.9	73.3	51.3	70.0	39.0	42.9	28.6	47.6
Y	39.1	43.4	37.2	58.9	37.9	57.6	26.7	28.1	36.4	42.7
Z	30.5	36.6	37.2	56.6	30.8	36.7	28.6	31.4	29.9	45.2

conducting conveying touch and proprioception as well as motor activation. Pain is transmitted by thinly myelinated or unmyelinated fibers (δ fiber or C fiber).

Our studies clearly indicated that carbamazepine will block Delta fibers first but also slow the conduction velocity of α fibers and finally block both fiber potentials. The conduction rate of the slowly conducting A fibers was slowed more than that of the fast conducting A fibers at the doses of carbamazepine given here.

Significance of peak velocity changes was larger than the significance of inflection velocity alterations generally, when recording at the more distal segments of the nerve from the stimulating electrodes.

During the period of spontaneous attacks, a minimum stream of afferent impulses in the trigeminal nerve is evidently sufficient to provoke an attack. Thus, the nerve is in a state of extremely lowered threshold and hyperexcitability.

Our studies indicate that carbamazepine will increase threshold of the peripheral nerve even in small doses (4 mg./kg.). Furthermore, carbamazepine will block hyperexcitability and decrease threshold produced by a brief period of tetanic stimuli and enhance recovery of the nerve. Carbamazepine prevents spontaneous firing produced by sodium oxalate or phosphate, which may simulate the "spontaneous attack" state of tic douloureux.

Summary

The studies summarized the results of examinations on 172 sciatic nerves of rats for the purpose of determining the effect of carbamazepine and dilantin. Carbamazepine will increase threshold of a nerve to electrical stimuli and decrease or block slow conducting A fiber, especially δ fiber. Carbamazepine will diminish hyperexcitability state produced by tetanic stimuli or sodium oxalate or phosphate. Carbamazepine has effect on peripheral nerve which could be the mechanism of drug effect on tic douloureux.

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The magnitude of the Medicaid Program dictates that research to determine utilization patterns will be advantageous for planning and evaluation of medical care programs that may be proposed in the future.

Medicaid Utilization in Georgia Hospitals for Fiscal 1971

DAVID BROUSSARD, GYLL ZAROVSKY, BEAUFORT LONGEST, Ph.D.
and GERTRUDE ENZWEILER, *Atlanta*

IN THIS STUDY, evaluation of the impact of Medicaid upon the hospitals in Georgia is undertaken through a research methodology which assesses the utilization of hospital facilities by Medicaid patients. Further analysis is made by geographical grouping of place-of-service to identify the distinctive patterns of utilization which may be occurring within the health districts recently organized in Georgia. The study is limited to fiscal year 1971.

The scope of Medicaid involvement in Georgia is attributable to the relatively large number of persons eligible for Medicaid services. There were 419,556 persons eligible for public assistance in June 1971, the closing month of fiscal year 1971, and thus eligible for Medicaid. The records of the Department of Family and Children Services identify 37,300 persons who were dropped from welfare eligibility rolls during the fiscal period for reasons of death, income changes, etc. An additional 15 to 18 thousand persons were eligible for medical assistance only, their care being provided by Medicaid principally in nursing homes. Thus, more than 470,000 persons (approximately one out of every ten Georgians) were eligible for Medicaid services at some point during the 1971 fiscal period.

Provision of care to Medicaid recipients is expected to generate 7,000,000 claims for the current fiscal year (1972), representing an outlay of \$115,765,734. This amount includes \$107,962,885 provided by the federal government. The State of Georgia's share of Medicaid payments represents approximately \$47,802,849 or 4 per cent of the State's total budget for fiscal 1972.¹ This amount includes an allocation of \$35,369,010 for inpatient hospital ser-

vices, which compares with \$29,907,031 cash disbursements for these services in fiscal 1971.

Not all of this care is provided in Georgia hospitals. Some participating hospitals are in bordering states and provide an access to services that is consistent with established customs of seeking care. A certain amount of emergency care is provided in out-of-state facilities. Administrative activities of the Georgia Medical Assistance Program (Medicaid) employ computerized surveillance methods to monitor utilization of services. In this paper, the research design draws upon the data generated in monitoring the experience of hospitals participating in the Medicaid Program. The source data is the retrieval of claims payment information collected on a quarterly basis and finalized upon completion of fiscal year expenditures. Application of this inpatient utilization data for fiscal 1971 is restricted to claims processed and is pursued for more refined research than the routine purposes of administrative program control.

Persons eligible for Medicaid include all ages of welfare recipients. By contrast, Medicare is much more limited since it covers only persons 65 years and older. Medicaid buys into Medicare for eligible Old Age Assistance recipients. Persons with dual eligibility receive inpatient care under Medicaid only after they have exhausted Medicare benefits. The nature of this arrangement lends itself to research that would jointly define the amounts of hospital care excluded by Medicare and the types of long-term care being provided by Medicaid for persons 65 years and older. These variables of recipient eligibility have implications for assessing Medicaid rates of inpatient utilization and are perti-

nent to conclusions that may be drawn from this study.

Data Collection

Since the in-state hospitals participating in Georgia's Medicaid Program do not comprise a large population, the entire population was studied rather than employing a sampling technique.

Primary utilization data by type of service, collected by the Medicaid Evaluation Section of the Georgia Department of Public Health, is utilized in this study. The number of inpatient admissions is represented by the number of hospital claims processed by Medicaid in fiscal 1971. Services provided during a hospital stay are usually submitted for payment on a single claim form. The time lag between the date of service and the date the claim is paid by Medicaid must be considered. This delay can involve several months.

The data provided by the Medicaid Evaluation Section is in the form of computer printouts, by hospital, by elements of available information. From these sheets and other sources described below, the following information was obtained:

- Name of Hospital
- Town
- District
- Number of beds
- Locality class: urban, intermediate, or rural
- Number of Medicaid claims for fiscal 1971
- Number of patient days provided Medicaid patients
- Percent of occupancy by Medicaid patients
- Average length of stay of Medicaid patients

Since the Medicaid printouts did not list towns, the Guide Issue of *Hospitals, J.A.H.A.*, was used to obtain this information.

Fifteen districts have been established by the Georgia Department of Public Health in administrative de-centralization. These districts are:

- Northwest (NW)
- Northeast (NE)
- North (N)
- Fulton County (F)
- Metro East (ME)
- Metro West (MW)
- West (W)
- West Central (WC)
- East Central (EC)
- East (E)

- North Central (NC)
- South Central (SC)
- South (S)
- Southeast (SE)
- Southwest (SW)

The composition of the districts by county is as follows:

NORTHWEST DISTRICT: Catoosa, Chatooga, Dade, Fannin, Floyd, Gilmer, Gordon, Murray, Pickins, Walker, Whitfield.

NORTH DISTRICT: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White.

FULTON DISTRICT: Fulton.

METRO WEST DISTRICT: Bartow, Cherokee, Cobb, Douglas, Haralson, Paulding, Polk.

METRO EAST DISTRICT: Clayton, DeKalb, Gwinnett, Henry, Rockdale.

NORTHEAST DISTRICT: Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton.

WEST DISTRICT: Butts, Carroll, Coweta, Fayette, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson.

EAST CENTRAL DISTRICT: Burke, Columbia, Emanuel, Glascock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes.

NORTH CENTRAL DISTRICT: Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Macon, Monroe, Peach, Putnam, Pulaski, Twiggs, Wilkinson.

EAST DISTRICT: Bryan, Bulloch, Candler, Chatham, Effingham, Evans, Liberty, Tattnall.

SOUTH DISTRICT: Berrien, Brooks, Cook, Echols, Irwin, Lanier, Lowndes, Tift.

SOUTH CENTRAL DISTRICT: Ben Hill, Bleckley, Dodge, Jeff Davis, Johnson, Laurens, Montgomery, Telfair, Toombs, Treutlen, Wheeler, Wilcox.

WEST CENTRAL DISTRICT: Chattahoochee, Dooley, Harris, Marion, Muscogee, Quitman, Schley, Stewart, Sumter, Talbot, Taylor, Webster.

SOUTHEAST DISTRICT: Appling, Atkinson, Bacon, Brantley, Camden, Charlton, Clinch, Coffee, Glynn, Long, McIntosh, Pierce, Ware, Wayne.

SOUTHWEST DISTRICT: Baker, Calhoun, Clay, Colquitt, Crisp, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Randolph, Seminole, Terrell, Thomas, Turner, Worth.

The evaluation reports do not include the districts in which hospitals are located. This information was obtained by determining the location (county) of each hospital in the Guide Issue of *Hospitals*,

J.A.H.A. Counties were then identified by health district according to an organization map provided by the Georgia Department of Public Health.

The number of beds was, in most cases, listed on the Medicaid printouts. Where it was not given, the Guide Issue of *Hospitals, J.A.H.A.* was again consulted.

Locality classes are defined as urban (U), intermediate (I) and rural (R) in this study. The U.S. Bureau of the Census defines an urban community as one of at least 50,000 population.² Cities so defined (and the counties in which they are located) in Georgia include the following:

Augusta (Richmond County)	59,864
Albany (Dougherty County)	72,623
Savannah (Chatham County)	118,349
Macon (Bibb County)	122,423
Columbus (Muscogee County)	154,168
Atlanta (Fulton County)	496,973

It should be noted that Atlanta, a major metropolitan center, has several suburban areas, and the metropolitan area has approximately 1.4 million population. In addition, Atlanta has many of the “inner core” problems typical of today’s large urban centers. For these reasons, Atlanta (Fulton and DeKalb Counties) is treated in this study as a separate category (urban). The other cities listed above (and the counties in which they are located) are categorized intermediate, and all other areas are considered rural.

The number of Medicaid claims was, in every case, obtained from the Medicaid printouts, as was the number of patient days provided to Medicaid patients.

The percent of occupancy by Medicaid recipients is the result of the formula:

$$\frac{\text{Number of patient days provided Medicaid patients}}{365 \text{ days} \times \text{number of beds in hospital}}$$

This represents the ratio of Medicaid patient days to available bed days in the hospital. In most cases, this figure was provided in the Medicaid printouts, but where the number of beds was not available from the printouts, there was of course no derived ratio figure. In these cases, the ratio was computed by the authors.

Average length of stay of Medicaid recipients is computed as follows:

$$\frac{\text{Number of patient days provided Medicaid patients}}{\text{Number of Medicaid Claims}}$$

This figure is provided, in all cases, on the Medicaid printout.

Additional data was obtained from a chart titled “Population—Individuals Receiving Assistance, December 31, 1970,” which was used in a presentation by Jim Parham, Director, Georgia Department of Family and Children Services, to the Georgia Senate on June 22, 1971.³ This chart lists two items which were used in the study. They are (1) population, and (2) individuals receiving public assistance money payments for each county in Georgia.

Data Manipulation

The computations for this study were made by the computer at the Georgia State University Computer Center. A program was written to calculate the following information for each district and locality.

- 1. Total beds for locality and district
- 2. Total number of claims for locality and district
- 3. Total number of patient days for locality and district
- 4. Total percent of occupancy for locality and district
- 5. Total average length of stay for locality and district

The percent of population eligible for welfare in the state, districts, and localities was computed by summing the total population for each respective group of counties and the total number of welfare recipients for each respective group of counties, then dividing the number of welfare recipients by the total population. The data collected in this study is contained in Table I.

Column 1 shows the percent of occupancy of Medicaid patients for the state as a whole; for urban, intermediate, and rural; and for each district. The ratio of the figure for each district and locality to the figure for the state is shown in parentheses. The percent of occupancy for the state, each locality, and each district, was computed by summing the necessary data and applying these totals to the formula given earlier.

Column 2 represents the computed average length of stay for the state, localities, and districts. The ratio of each locality and district to the computed figure for the whole state is also presented.

Column 3 represents the percent of people eligible for public assistance (money payments) in the state and each locality and district. The ratio of each locality and district to the state figure has been computed and shown.

Column 4 is the ratio of the percent of occupancy by Medicaid patients to the percent of total population eligible for public money assistance. This is important because no matter how the percent of occupancy varies among districts and among localities, these comparisons are not meaningful unless they are related to the percent of the population eligible for this form of public assistance; i.e., one would expect a higher rate of Medicaid utilization in an area which has a higher participation rate in public assistance.

Conclusions

Of the three locality classes, urban hospitals are shown to have the lowest percent of occupancy of Medicaid patients. The urban area studied also has the lowest percentage of potential Medicaid recipients.

In contrast, the rural areas show a significantly higher Medicaid utilization rate and a significantly higher rate of eligible welfare recipients. It is interesting that the ratio of percent of occupancy to percent of population eligible for welfare is roughly the same for urban and rural areas. While the derived ratio is considerably higher for intermediate areas, the percent eligible for welfare in intermediate areas is almost identical to percent eligible in rural areas.

This delineation does not show a trend of high

Medicaid usage in either rural or urban areas and suggests that the identification of trends, if they do exist, requires time-series study. Since the present study is based on expenditure data only and records experience by place of service rather than by residence of recipient user, it is possible that the highest rate of Medicaid occupancy occurs in intermediate locality hospitals because of referral patterns originating in the rural settings.

The fact that the ratio of percent of occupancy by Medicaid patients to percent of population eligible for welfare for the state as a whole is 1.00 offers support for the validity of this ratio as a basis for comparison. Because of this one-to-one ratio, it can be assumed that, as the percentage of welfare recipients varies, so will Medicaid utilization.

It is interesting to note on a health district basis that the ratios of percentage of occupancy by Medicaid patients to percent of population eligible for welfare tend to show groupings but present no strong pattern. An intimate knowledge of the socio-economic make-up of each district would be necessary to evaluate the concentrations of similar ratios and to establish a valid comparison of Medicaid utilization by the various health districts. Such an analysis might provide an explanation for the extremely high ratios for the Metro East and Metro West Districts.

The computed averages for length of stay indicate that urban hospitals have a longer length of stay than do rural hospitals, 8.78 days as compared to

TABLE I
DATA COLLECTED IN THE STUDY AND SELECTED RATIOS

	(1) Percent of Occupancy by Medicaid Patients and Ratio to State	(2) Average Length of Stay of Medicaid Patients and Ratio to State	(3) Percent of Population Eligible for Welfare and Ratio to State	(4) Ratio of Column (1) to Column (3)
State	9.41	7.39	9.36	1.00
Locality Class				
Urban	6.71(.71)*	8.78(1.18)	7.14(.76)	.94
Intermediate	11.29(1.20)	8.01(1.08)	10.02(1.07)	1.13
Rural	9.85(1.05)	6.80(.92)	10.08(1.08)	.98
Districts				
Northwest	7.84(.83)	6.39(.86)	5.93(.63)	1.32
North	8.83(.94)	8.21(1.11)	6.81(.73)	1.30
Northeast	8.69(.92)	7.52(1.01)	7.73(.83)	1.12
North Central	11.75(1.25)	6.28(.85)	10.32(1.10)	1.14
Metro East	4.59(.49)	9.20(1.22)	2.80(.30)	1.64
Metro West	6.16(.65)	7.12(.96)	3.79(.40)	1.63
Fulton	7.37(.78)	8.50(1.15)	10.30(1.10)	.72
Southeast	14.68(1.56)	7.57(1.02)	10.53(1.13)	1.39
South Central	11.84(1.26)	5.89(.80)	12.53(1.30)	.94
Southwest	10.75(1.14)	7.00(.95)	13.03(1.40)	.83
East	14.18(1.50)	7.99(1.08)	10.00(1.07)	1.42
South	11.70(1.24)	6.23(.84)	9.93(1.06)	1.18
East Central	9.55(1.01)	8.20(1.10)	11.87(1.27)	.80
West	8.73(.93)	6.54(.88)	10.09(1.08)	.87
West Central	10.36(1.10)	7.82(1.06)	10.04(1.07)	1.03

* Ratio to State

6.80 days. The average length of stay for the state was 7.39 days. The fact that the shortest length of stay is associated with rural hospitals reveals interesting aspects of the Medicaid program. The authors had expected that just the opposite situation would be found with the urban tight-bed situation influencing a shorter length of stay. The unexpected pattern may be due to the fact that inpatient care of the elderly, which characteristically shows a longer length of stay than for other age groups, is provided under Medicare on buy-in arrangements for Medicaid recipients.

The shorter average length of stay in rural hospitals may be further influenced by the large number of admissions covered by Medicaid for obstetrical deliveries without complication. Such care is normally a three-day hospitalization provided close to the recipient's place of residence. Thus, the higher number of minimum stays—those less than three days—which may be occurring in the rural areas (which show the highest percentage of welfare eligibles) may account for a reduction in the overall average for length-of-stay experience of Medicaid patients in Georgia's rural hospitals. In retrospect it seems that case severity in urban hospitals has some relationship to the observed longer length of stay al-

though individual case evidence is beyond the scope of this study. An investigation to determine factors affecting the longer length of stay in urban hospitals would be of value.

Two major implications of this study are:

(1) Medicaid utilization should be carefully monitored, particularly in those districts where the ratio of percent of occupancy by Medicaid patients to percent of welfare recipients is over 1.00.

(2) Intermediate areas should be carefully monitored, since, as a group, they have a high ratio of percent of occupancy to percent of welfare recipients. Tracing patient residence origins may yield information which accounts for how and why hospitals in the intermediate localities are heavily utilized by Medicaid patients.

Georgia State University
33 Gilmer Street, S.E. 30303

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2. 1970 Census of Population, Number of Inhabitants—Georgia, U.S. Department of Commerce, Bureau of the Census, Washington, D.C., July, 1971, p. VII.
3. Jim Parham: *Statement to legislative committee on Medicaid*; Georgia Department of Public Health, Family and Children Services (Atlanta, Georgia, June 22, 1971).

1973 ATLANTA GRADUATE MEDICAL ASSEMBLY PROMISES FULL SCHEDULE

Thirty outstanding speakers have been gathered for the 30th Annual Session of the Atlanta Graduate Medical Assembly March 4-7 in Stouffer's Atlanta Inn.

Included in the speakers are Paul B. Chretien, M.D., Deputy Chief of the Surgery Branch of National Cancer Institute in Bethesda, Md.; Ernest Craige, M.D., Henry A. Foscue Distinguished Professor of Cardiology at the University of North Carolina School of Medicine; William E. Lotterhos, M.D., Professor and Chairman of the Department of Family Practice of the Medical College of Georgia in Augusta.

Ennio C. Rossi, M.D., Professor of Medicine at Northwestern University School of Medicine in Chicago, Ill.; Tiffany J. Williams, M.D., Section of Gynecologic Surgery of the Mayo Clinic in Rochester, Minn.; Jerome O. Klein, M.D., of Department of Pediatrics of Harvard University School of Medicine; and Norman C. Nelson, M.D., Department of Surgery, Tulane University School of Medicine in New Orleans, La.

A day's schedule devoted to several special areas has been planned through the cooperation of the sponsoring Medical Association of Atlanta and the Georgia Heart Association; Georgia Chapter, American College of Surgeons; Georgia Academy of Family Physicians; Greater Atlanta Pediatric Society; Atlanta Obstetrical and Gynecological Society; and Georgia Division, American Cancer Society.

Monday, March 5 is "Day of Surgery" and "A Day of Cardiology"; March 6 is "A Day of Obstetrics and Gynecology," "A Day of Pediatrics and Internal Medicine," "Infectious Disease and Immunology" and a "Day of Cancer"; March 7 is "A Day of Family Practice" and "A Day of Hematology."

Registration is \$10 for members of the above associations, with registration \$50 for visitor M.D.'s. Correspondence and questions should be directed to the Atlanta Graduate Medical Assembly, 875 W. Peachtree Street, N.E., Atlanta, Georgia 30309.

Initial efforts in five stations show good results in combating the problem of medical care availability.

Health Access Stations

J. GORDON BARROW, M.D.,* *Atlanta*

DOCTORS OF THE STATE are beginning to realize that medical care is considered by most to be the right of all citizens and, if the profession does not solve the problem of accessibility and availability of care in areas where it is deficient, the state or federal government will probably take steps to solve it.

I am sure that most doctors would prefer to seek acceptable solutions which do not violate the principles in which most of us believe. For this reason the Task Force on Primary Health Services of the Georgia Regional Medical Program (GRMP), which is made up principally of providers of health services who are involved in the everyday delivery of care, studied the need and made certain recommendations as to possible approaches which might be tried.

It should be clearly understood that these are all considered to be field trials and results of these trials will be studied before final recommendations are made as to the best possible solution to this problem of accessibility and availability of medical care to all citizens.

One of the approaches recommended by the task force and approved by the Regional Advisory Group of GRMP was the use of Health Access Stations. These were to be located in rural areas in which there was either no physician or a gross shortage of physicians and in urban low income areas where accessibility to a physician was a problem.

The Health Access Station was to serve five basic purposes:

1. To provide emergency first aid when needed;
2. To provide transportation, if needed, to and from the physician or nearby hospital;
3. To assist the patient who does not have a physician to obtain one;
4. To assist the physician in the assessment of the clinical condition of the remote patient so that a proper decision can be made by the physician as to the need for the patient to come to his office (or the hospital) or whether treatment could be safely

ordered by the physician to be given by the nurse in the station;

5. To assist the physician in follow-up of his patient and assist the patient in carrying out the physician's instructions.

In every case where the patient already has a physician, this physician is contacted and given the information obtained by the nurse. He then makes the decision whether or not to have the patient come to his office (or to the hospital) or he may direct the nurse to institute certain treatment.

When the patient does not have a physician, he is referred to a nearby doctor. Care is taken that all doctors in the area, who have indicated they will take new patients, are used in rotation.

This Health Access Station concept was reviewed and approved by the Executive Committee of Council and later by the entire Council of the Medical Association of Georgia.

Initial Stations

During the first year, five Health Access Stations were established. They are located in Rochelle, Wilcox County; Danielsville, Madison County; McDonough, Henry County; Crawfordville, Taliaferro County; and in the McDaniel Street area in the City of Atlanta. They are variously sponsored by a city government, a local medical society, a state medical society, a medical foundation and a district health department. Each is supervised by a specific physician who reviews all records in the clinic weekly and designs a continuous program of education to improve any weakness identified.

Although the basic staffing of the stations has varied, experience has shown that two registered nurses who have considerable clinical experience, preferably in a doctor's office, are desirable. Each nurse should have in addition at least a two week course in basic history taking and simple physical examination as well as instructions in first aid for all the commonly encountered emergencies prior to opening the station.

We have been surprised at the infrequency that

* Director, Georgia Regional Medical Program.

the patients cannot provide some form of transportation. Experience has shown that, even if it is available, free transportation will be used less than 20 times each month. It is not feasible therefore to own and operate a vehicle with the necessity of having drivers around the clock. Usually some mechanism can be worked out within the community to provide the necessary transportation at a minimum cost per trip for those who cannot provide it personally.

The services of the Access Station are available to all in the community. A basic charge of \$1.00 is made for the services of the nurse. Medication given is charged at cost. No attempt is made to collect from those who cannot pay. To date it appears that almost 100 per cent can pay the fee although all of these are poor communities.

Although the use of each of the stations is still increasing, it appears that they will average in the neighborhood of 100 to 200 patient visits per month in an immediate population of 2,000 to 4,000 persons. About 60 per cent of these will be follow-up visits ordered by the physician. These stations are being utilized by both black and white as well as

adults and children in about the proportion to be expected from the population. As would be expected, female use predominates over male.

The stations are being enthusiastically received by the communities and, although there are individual exceptions, reception and utilization of the station is in general good by the area physicians. This is particularly true where the station is sponsored by the local medical society. The task force has recommended that, in the future, medical society or hospital staff sponsorship should be sought in all cases.

Whether or not health access stations will represent the eventual solution to the problems of accessibility and availability of medical care to areas under-supplied with health professionals remains to be seen. The results of these five must be studied longer and other alternative approaches must be tried, however this represents a first attempt to solve a difficult problem which must be solved by the profession if we do not wish a solution which is less acceptable to us to be imposed by government and society.

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C. F. GASTINEAU, M.D., Rochester, Minn.
Internal Medicine

JOSEPH D. GODFREY, M.D., Buffalo, N.Y.
Orthopedic Surgery

JAMES L. GROBE, M.D., Phoenix, Ariz.
Family Practice

KENNETH K. KEOWN, M.D., Columbia, Mo.
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JOHN M. KNOX, M.D., Houston, Tex.
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A. J. McADAMS, M.D., Pittsburgh, Pa.
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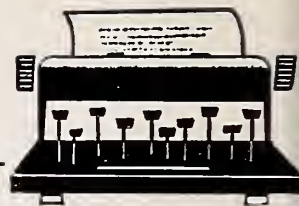
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The Georgia Heart Association Twenty-Five Years of Service 1948-1973

IN 1948 A GROUP of Georgia's leaders, medical and non-medical, met to organize a non-profit agency which could channel professional services and public financial support into a viable weapon against heart disease, the state's leading killer.

The result was the Georgia Heart Association, an affiliate of the American Heart Association. GHA is the only organization in the state devoted exclusively to fighting diseases of the heart and blood vessels.

This year marks the silver anniversary of the Heart Association and GHA physicians have played a forceful, effective role in serving the people of Georgia during the past 25 years.

More than 900 physicians in Georgia hold professional membership in the Association and enlist the voluntary professional service of hundreds more.

More than 250 physicians give their time to address both public and professional groups in cardiovascular subjects.

More than 200 physicians regularly give their time to serve indigent patients in Georgia's 14 Heart Clinics in a 12-month period. The time given to clinics by these physicians total more than 8,000 hours per year to serve 20,000 patient visits.

More than 250 physicians attend the annual meeting and scientific sessions of the Georgia Heart Association.

Hundreds of GHA physicians have participated as instructors in the Association's statewide training program in the life-saving technique of Cardiopulmonary Resuscitation (CPR), as speakers or authors cooperating with the news media in its efforts to educate the public about heart disease and as developers and coordinators for many educational seminars and programs throughout Georgia.

Perhaps more important than all the above is the fact that by joining hands with non-medical leaders in the organized fight against the cardiovascular diseases GHA physicians not only have multiplied their own effectiveness many fold, but identified themselves in their communities as leaders in the effort to advance knowledge which will benefit their patients and the community as a whole.

*Nicholas E. Davies, M.D.**

New PSRO's Allow Control by Organized Medicine

WITH THE ENACTMENT of Public Law 92-603, the medical profession is faced with its greatest challenge since the passage of Medicare and Medicaid. The Congress has finally recognized the error it made in allowing third parties to make professional judgments on the appropriateness and medical necessity of services pro-

* Member of the Board of Directors of the Georgia Heart Association and its Physician Education and Nurses' Education committees.

vided under federally funded health programs. Public Law 92-603 establishes Professional Standards Review Organizations (PSRO's).

PSRO's will conform to the following characteristics:

(1) The expense of PSRO's will be underwritten by HEW and they very likely will be organized on a regional basis.

(2) They must provide for open membership to both M.D.'s and osteopaths and may not require membership in, or the payment of dues to, any medical society as a condition for joining PSRO.

(3) The HEW Secretary will designate PSRO areas throughout the United States by Jan. 1, 1974. Until 1976, however, only organizations representing substantial numbers of physicians in a particular area can be designated as a PSRO.

(4) PSRO's must be nonprofit associations or a component part of a nonprofit association.

(5) They must be able to demonstrate their professional competence to review appropriate professional services.

(6) Physicians' organizations are to be given priority in the establishment of PSRO's. If no such physician organization exists, or is willing to assume this role in a given area, after Jan. 1, 1976, the HEW Secretary can designate a qualified public or nonprofit organization to serve as the PSRO.

(7) PSRO's must use only M.D.'s and D.O.'s to review actions of their peers.

(8) PSRO's initially will be required to review only institutional care. As soon as possible, however, they will be expected to review the professional activities of physicians and other health care practitioners, as well as institutional and non-institutional providers of services under programs paid for by Medicare, Medicaid and maternal and child health programs. PSRO's will determine whether services are medically necessary, whether the quality of care meets professionally recognized standards and whether or not the service was performed in an appropriate facility.

(9) There will be a structured appeals mechanism from decisions made by PSRO's.

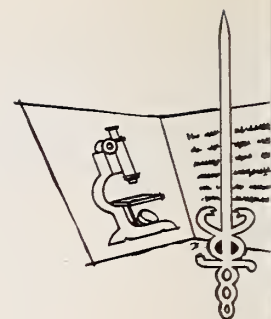
(10) Data gathered by PSRO's is to remain confidential.

The AMA's House of Delegates has created an Advisory Committee to HEW on Professional Standards Review. This Committee would also assist state and county medical societies in developing PSRO's. The AMA, as well as the MAG, had serious reservations about PSRO's and opposed this legislation while it was under consideration by the Congress. Now, however, since it is the law of the land, organized medicine hopes to make the best of poorly thought out legislation.

Here in Georgia, the MAG had the foresight two years ago to create the Georgia Medical Care Foundation. The Foundation has been functioning as a medical review agency for the state's Medicaid program for the past year. The Georgia Foundation will submit a proposal to the Secretary of HEW for its designation as a state-wide PSRO.

The effect of P.L. 92-603 will no doubt be very far reaching. Your Medical Association is ready to serve and assist its members to receive fair and equitable treatment through this new review mechanism which organized medicine has an opportunity to control.

For additional information on PSRO contact the MAG Headquarters office, 938 Peachtree Street, N.E., Atlanta, Ga. 30309.



CONTINUING MEDICAL EDUCATION ON CANCER IN GEORGIA

JOHN I. DICKINSON, M.D.,* *Rome*

A RECENT ARTICLE in the September 11, 1972 issue of the *American Medical News* has prompted the Professional Education Committee of the Georgia Division to consider what it is doing and what its future course of direction should be. At present it is committed to providing the latest information on cancer, its diagnosis and management, for members of the medical profession and its allied counterparts. Plans for this year's activities have already been laid and will continue as planned. Future efforts can be changed, however, in accordance with the suggestions from physicians in Georgia who are concerned with the time workshops, seminars, etc. take away from their already overworked practice of trying to treat patients.

Activities at present include: "CA—A Cancer Journal for Physicians" is mailed bi-monthly to all physicians, medical students, hospital medical libraries and the libraries of nursing and dental schools. This publication provides the latest information available on developments in chemotherapy, diagnostic techniques, current concepts on various treatment techniques, etc. In addition, there are many publications such as monographs, proceedings of meetings, manuals and pamphlets, as well as films and other audio visuals that are available on request from the American Cancer Society.

As for workshops, seminars and other programs of this type, this committee in 1973 is working closely with the Committee on Cancer of the Medical Association of Georgia and the Georgia Regional Medical Program to co-sponsor workshops in various areas of the state.

Listed below is important information regarding two of the forthcoming programs to be held in March, including the speakers and their subjects:

March 6, 1973, "DAY OF CANCER": Co-sponsored with Atlanta Graduate Medical Assembly, Stouffer's Atlanta Inn, 590 West Peachtree. For registration, contact Atlanta Graduate Medical Assembly, 875 Peachtree St., N.E., Atlanta, Ga. 30308.

Benjamin F. Byrd, Jr., M.D.
Vanderbilt Univ. School of Medicine
Nashville, Tennessee

"Selection of Surgical Procedures in
Management of Carcinoma of the
Breast"

J. Shelton Horseley, III, M.D.
University of Virginia School
of Medicine
Charlottesville, Virginia

"Management of Thyroid Cancer"

* Chairman, Professional Education Committee, American Cancer Society, Georgia Division, Inc.

Richard G. Martin, M.D.
M. D. Anderson Hospital and
Tumor Institute
Houston, Texas

"Management of Carcinoid Tumor of
the Gastrointestinal Tract"

George P. Rosemond, M.D.
Temple University School of Medicine
Philadelphia, Pennsylvania

"Carcinoma of the Esophagus"

Paul B. Chretien, M.D.
National Cancer Institute
Bethesda, Maryland

"Clinical Significance of Immunological
Reactivity of Cancer Patients"

Rodney Million, M.D.
University of Florida
School of Medicine
Gainesville, Florida

"Indications of Radiotherapy in Treat-
ment of Cancer"

Workshops on Cancer, co-sponsored by the Committee on Cancer of the Medical Association of Georgia, the Georgia Regional Medical Program and the American Cancer Society, Georgia Division for the coming year include, on March 16 and 17, "IMMUNOTHERAPY AND CHEMOTHERAPY FOR MALIGNANT DISEASES," presented by the Columbus Medical Center and the Enoch Callaway Cancer Center in La Grange. This will be held conjointly with the meeting of the Sixth District, Medical Society, in the Conference Room at Callaway Gardens.

Reservations for this workshop should be forwarded to the American Cancer Society, Georgia Division, Inc., 2025 Peachtree Road, N.E., Atlanta, Georgia 30309. The featured speakers and their subjects are as follows:

John M. Bennett, M.D.
Associate Professor of Medicine
University of Rochester
School of Medicine
Rochester, New York

"Multidisciplinary Management of Solid
Tumors" . . . "New Chemotherapeutic
Agents in Solid Tumors" . . . "Review
of Histological Types of Hodgkins Dis-
ease" . . . "New Concepts in Pathologi-
cal Classification of Non-Hodgkins
Lymphoma."

Paul B. Chretien, M.D.
Deputy Chief, Surgical Branch
Head, Tumor Immunology Section
National Cancer Institute
Bethesda, Maryland

"Clinical Implication for Pathological
Classification of Melanoma" . . .
"Chemotherapy and Immunotherapy in
Melanoma" . . . "Indication for Lap-
arotomy for Staging Lymphomas"

Russell R. Moores, M.D.
Professor of Humanities and Medicine
Associate Dean, Medical College
of Georgia
Augusta, Georgia

"Clinical Staging of Lymphomas" . . .
"Therapy of Lymphomas"

John D. Watson, M.D.
Area Facility Director, GRMP
Columbus Medical Center
Columbus, Georgia

"Radiation Therapy"

Two workshops on gynecological cancer are to be held in April—one in Savannah on April 21, 1973 for physicians in southeast Georgia, and a second at a date and place to be selected soon for physicians in southwest Georgia.

The Medical College of Georgia and the Augusta Radiation Center and Tumor Institute are planning to present a workshop on "Diagnosis and Management of Gastrointestinal Cancer" on October 12, 1973. Further information on the latter two workshops will be available at a later date.



MANAGEMENT OF ANGINA: LONG-ACTING CORONARY VASODILATORS

I. W. JOINES, II, M.D., *Atlanta**

THE TOPIC FOR discussion, as titled, is in itself an overstatement of the facts and therefore misleading; that nitroglycerin (the time-honored and key drug in the treatment of angina) actually dilates the coronary arteries, has been disputed by respected investigators; however, the best data validates its action as a coronary artery dilating agent.

Controversy exists as to the mechanism whereby nitroglycerin effects relief of angina; the consensus is that reducing MVO₂ (myocardial oxygen consumption) through effect on several determinants of MVO₂ is the most plausible explanation. These determinants are heart rate, arterial pressure, preload, ventricular volume and mass, and contractility. Prinzmetal's variant angina cannot be explained by an increase in MVO₂ since it is not preceded by an increase in heart rate or arterial pressure; it is thus reasoned that the angina results from a reduction in coronary perfusion probably due to coronary artery spasm.

Even more controversy exists as to the efficacy of "long-acting" drugs of the nitrate group; some contend that isosorbide is ineffective when taken orally and no more effective or longer acting than nitroglycerin when the sublingual route is used. Patients and their physicians will zealously defend and, on the other hand, attack various preparations mostly basing their opinions on purely subjective data at best. To contend that the production of headache by oral preparations is proof of action on the coronary arteries is to ignore the possibility of selective action on the cerebral vasculature to the exclusion of the coronary circulation. Perhaps the patient is "trading angina for a headache."

There is ample evidence that packaging, compounding techniques and all other factors which influence rate and/or location of absorption and entry into the blood stream do, to a large extent, determine clinical effectiveness. Who would defend the value of a preparation repeatedly shown to pass relatively unaltered in the stools of patients?

Then consider the controversy as to whether any drug or clinical compound is, in fact, long-acting (as compared to nitroglycerin). While reports on the effectiveness of various preparations are conflicting and confusing, there is general agreement that long-acting nitrates such as erythrityl tetranitrate (Cardilate), isosorbide dinitrate (Isordil) and pentaerythritol tetranitrate (Peritrate) can be shown to have durations of action for periods of from 1 to 4 hours. However, the magnitude of response is not as great as compared to the clearly shorter-acting parent compound, nitroglycerin.

Protocols designed to measure prophylactic effectiveness have differed in results and, hence, conclusions apparently because of variations in time lapse and (stress) testing and exercise work loads between drug administration and staging. These data apply only to the sublingual or chewable preparations; oral preparations have been demonstrated no more effective than placebo. Sustained action preparations are held ineffective.

Another coronary vasodilator, dipyridamole (Persantine), has fallen into disuse because it is ineffective in relief and prophylaxis of angina due to the fact that it

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

selectively enhances blood flow to the epicardium rather than hypoperfused endocardium.

Many claims put forth by pharmaceutical manufacturers are based on unpublished, uncompleted studies from single investigators whose data and references are unavailable to the physician who has to examine and reach his own conclusions. All such studies are difficult due to the very subjective nature of so many of the parameters to be investigated.

Topical preparations of nitroglycerin (Nitrol Ointment) are effective in dosages of 1-2 inches in diameter on an extremity (usually the forearm) especially at bedtime to prevent nocturnal angina. Some patients with unusual anginal patterns often causing discomfort for hours at a time prefer the nitroglycerin ointment every 4 to 6 hours to the intermittent sublingual use of nitroglycerin or isosorbide. Adequate data on this mode of therapy are not available.

In summary, short-acting nitroglycerin is the standard against which all other preparations are measured; it is unexcelled in degree or magnitude of response and rapidity of onset of action. Preparations such as isosorbide dinitrate, erythrityl tetranitrate and pentaerythritol tetranitrate are long-acting but of a lesser magnitude of effect and with a substantially greater lag or delay between time of administration and onset of action. Substantial numbers of patients are treated with oral preparations of dubious effectiveness while others are treated with clearly ineffective sustained-action preparations; both groups all too often have not received nitroglycerin. Isosorbide, 2.5 mg. to 5 mg. sublingually, as often as every one and a half to three hours may be needed for effective prophylaxis. The physician is confronted with the need to select a reliable, proven preparation (as with digitalis compounds, preparations) and learn its actions well (both beneficial and potentially deleterious), always remaining mindful of the fact that individual responses and needs may dictate a different choice.

A meaningful patient-doctor relationship must be established to insure communication which is essential to a successful regimen of therapy.

*Suite 207-A
478 Peachtree St., N.E. 30308*

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LIQUIDITY OF UNREGISTERED INVESTMENTS

LAWRENCE M. GOLD, *Atlanta**

PHYSICIANS ARE being bombarded to an ever increasing degree with opportunities to invest in new enterprises offering prospects of large capital appreciation. Such investment opportunities can take many forms but are generally in the nature of interests in limited partnerships or stock in private corporations. These so-called "venture capital" investments usually supply initial capital for new enterprises, and because of the risks usually involved in any new venture, the merits or demerits of any particular investment must be carefully judged by the potential investor. One factor which a potential investor must consider and which is often overlooked is the liquidity of the investment. What if the project turns sour or what if a better prospect comes along in six months? Will the investor be able to sell the security or is he "locked in" for an indefinite period of time?

This article deals with the liquidity of such an investment in the context of federal and state securities laws. As you may know, both the states and the federal government have enacted laws which govern the offer and sale of "securities." Because venture capital investments involve the offer and sale of securities, the ability of an investor in one of these ventures to dispose of his interest, be it a limited partnership interest or stock, is regulated by both federal and state laws.

Federal Law

If the offering has been properly registered under the Securities Act of 1933 (the "Federal Act"), resale generally presents no problem. However, many fledgling companies in need of capital do not register the securities they are offering under the Federal Act because of the time and rather large expense involved in the registration process. Instead such companies rely on one or more exemptions from registration available under federal law. Two such exemptions that will be briefly discussed in this article are the so-called "intrastate" exemption and the "private placement" exemption. In both instances an investor may learn only too late that he is not free to dispose of his interest for quite some time.

Intrastate Exemption: The Federal Act established the intrastate exemption for securities offered solely to residents of a single state by an organization incorporated or organized under the laws of that state and which conducts substantial operations in that state. This means, for example, that a Georgia corporation operating in Georgia could offer its stock solely to Georgia residents and not be required to register such an offering under the Federal Act. For this exemption to be available the securities must be sold only to residents and they must hold the securities for a certain period of time before resale to any non-resident. How much time must an investor hold a security issued in reliance on this exemption? The Securities and Exchange Commission (the "SEC") has not set firm guidelines, although it has

* Prepared at the request of The Medical Association of Georgia. Mr. Gold is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

recently proposed a new rule that would require an investor to retain the security for at least one year prior to any sale to a non-resident. Sales to other residents of the same state may be permitted in less than one year so long as the buyers agree to the same restrictions.

The intrastate exemption is a risky one and may be easily lost if the security is sold to a non-resident. A sale to one non-resident destroys the entire exemption. Moreover, a resident who purchases the security with a view to its distribution and then sells it to a non-resident also destroys the exemption.

Private Placement: Another exemption frequently relied upon is the so-called "private placement" exemption which applies to the issuance of securities to a small group of so-called "sophisticated" investors in transactions that do not involve a public offering. Although the words "not involving any public offering" appear in the Federal Act, they have never been adequately defined. Courts, the SEC and state legislatures have all wrestled with the meaning of these words without totally satisfactory results. Consequently, no definite standards presently exist to determine when the private placement exemption is available. Some general standards have evolved over the years, but these are extremely complex and you should consult with your attorney for a full explanation of them.

The SEC has recently proposed a new rule that would set fairly objective criteria for determining the availability of this exemption. Generally speaking, if this rule is adopted, a private placement will exist if not more than 35 persons purchase the security during any twelve-month period; if these purchasers have been afforded information or access to information similar to that contained in a registered offering and have the opportunity to verify that information; if the investor is capable of evaluating the investment; and if he can afford the risk involved in the offering.

Assuming then that one has acquired a security in what is described as a private placement, when and under what circumstances may he dispose of it? As a general rule, one must acquire unregistered securities "for investment," meaning that he does not intend to make any distribution of the security for an indefinite period of time. Unless the security is registered under the Federal Act or unless an exemption from registration is available for the resale, the security must be held indefinitely. It must be remembered that any sale of a security must be registered or be exempt under the securities laws.

An investor who desires to resell an unregistered security acquired in a private placement must establish his own exemption and may not necessarily rely on the same exemption that was available to the company issuing the security. In fact, a resale of a security in violation of the securities laws may destroy the company's exemption. For example, an investor who attempts to resell an unregistered security soon after purchasing it in a private placement may endanger the private placement exemption itself because the claim that he purchased "for investment" is destroyed. Thus an investor may find himself not only liable to a subsequent purchaser for violating the securities laws but, because private placements usually require an investor to indemnify an issuer for violations of securities laws, he may also be liable to the company.

Rule 144, referred to above, does permit limited sales of securities acquired in private placements. It generally does not apply to securities acquired in an intrastate offering unless that offering would also constitute a private placement. In order for this rule to be available, the company issuing the security must make publicly available current information concerning its business and operations either by submitting reports to the SEC under its reporting requirements or by widely disseminating information concerning its business and financial condition.

There are other requirements for the availability of Rule 144 as well as limitations on the amount of and the manner in which securities may be sold. For purposes

of this article, the most significant requirement is that in order to sell securities under Rule 144, one must have held them for at least two years. If, as often happens, an investor issues a note as payment for the securities, the two-year holding period does not commence until the note has been fully paid.

Even if one can find a way to dispose of a security acquired in a private placement or an intrastate offering, the process is more complex than merely delivering one's certificates to a broker with a sell order. Certificates representing unregistered securities typically bear a conspicuous legend which restricts transfer and usually an opinion of counsel for the issuing company is required to the effect that the security may be transferred. Consequently, the sales process may take time since counsel for the issuing company will need to render an opinion permitting transfer and the selling broker, if any, will need to obtain certain information in order to be able to sell the security if the sale is made under Rule 144.

State Law

States have also adopted securities laws (called "Blue Sky" laws) to regulate offers and sales of securities within their borders. Naturally, such laws vary greatly from state to state and the Georgia Securities Act cannot be adequately described in this brief article. Suffice to say that even if an offering is exempt under federal law it may not be exempt under state law. You should consult with your attorney concerning this aspect of any proposed unregistered offering.

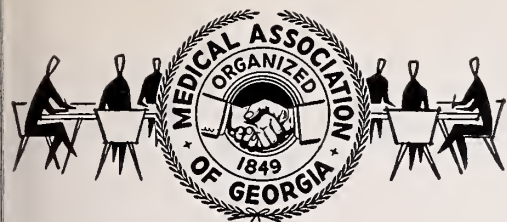
Effect on Issuing Company

We have briefly discussed the statutory limitations on resale of certain unregistered investments. What, however, are the consequences if the company issuing the security fails to establish its exemption for the initial issue? From the investor's point of view, the results are not necessarily all bad but they surely are to be avoided. Dissatisfied investors (and they usually all are when the z-rays turn out to be no more effective than cream of wheat) may demand the return of their investments. Of course, there may be no money to refund. But what if an investor is not dissatisfied and thinks the company still has a chance? In that case, the company has a contingent liability that could wipe out its financial resources. Should other investors demand their money back, more than likely the enterprise is doomed.

Conclusion

This article has dealt generally and in summary fashion with certain aspects of federal and state securities laws. It does not completely analyze this complex subject and certain areas have not been discussed due to space limitations. For example, there are special rules affecting investors who become "insiders," i.e., officers or directors of the venture, and these have not been mentioned. Its purpose has been to emphasize one often neglected facet of private investing: the very serious problems concerning the liquidity of the investment. After making a private investment one may find that he needs the money for other purposes and be unable to obtain it. Even if he is happy with the enterprise, other investors may ruin the venture by demanding the return of their investments for violations of federal or state securities laws. Worst of all, if an investor violates the securities laws, he may find he has incurred personal liability that he never anticipated. You should consult with your attorney before making any private investment in order to resolve any problems in this area.

*Eleventh Floor
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THE ASSOCIATION

SOCIETIES

The **Bibb County Medical Society** has adopted a resolution pledging greater support in combatting drug abuse in Macon and Middle Georgia. Among the points in the statement were: frequent marijuana usage over a long period may cause serious psychological and physical impairment; misuse and abuse of tranquilizers and barbiturates are common problems among large segments of the population; in addition to personal deterioration, the adverse aspects of heroin addiction include increased crime and community deterioration.

The 1973 **DeKalb County Medical Society** officers have been selected and are as follows: president-elect Benjamin B. Okel; vice president, Lawrence L. Freeman; secretary-treasurer, Wytch Stubbs; corresponding secretary, Philip Jardina; delegates to MAG, Charles McDowell, Lamar McGinnis, Duane Blair and Roy Vandiver; alternate delegates, Robert Hubbell, Paul Black, Richard Parsons and George Jones.

During its quarterly meeting in December, the **Ocmulgee Medical Society** elected the following officers for the coming year: president, Blake Bivins, of Cochran; vice president, Hart Sylvester of Hawkinsville; secretary-treasurer, George Patterson of Eastman; first delegate to MAG, Richard L. Smith of Cochran; alternate delegate, W. E. Coleman of Hawkinsville.

Luther M. Thomas, Jr. is newly elected president of the **Richmond County Medical Society**. Other officers are J. Kenneth McDonald, president-elect; John Martin, vice president; and John Phinizy, secretary-treasurer.

PERSONALS

First District

J. Robert Logan of Savannah has been elected president of the medical and dental staff of St. Joseph's Hospital. A graduate of Georgetown University School of Medicine, Dr. Logan served his residency at Emory University School of Medicine and Grady Hospital in Atlanta and is in the practice of otolaryngology.

Second District

Edwin D. Flournoy, Jr. of Albany has been appointed to the Committee on Scientific Programs of the American Academy of Family Physicians, with a term to expire in 1975.

Third District

James Dudley of Americus has been appointed by Gov. Jimmy Carter to serve on the Composite State Board of Medical Examiners from the Third Congressional District for a term ending Sept. 1, 1976.

Lamar S. McGinnis has been elected chief of the medical staff at DeKalb General Hospital, succeeding **Robert I. Gibbs, Jr.** Vice chief is **Timothy Harden, Jr.**, and **Russell W. Wallace, Jr.** is secretary. Newly-elected chiefs of departments are: Department of Gen-

eral Practice, **Garland P. Bennett**; Department of Medicine, **H. H. Butterworth**; Department of Obstetrics/Gynecology, **Horace C. Ball**; Department of Psychiatry, **Charles W. Walden**.

Fifth District

A. Alan Paulk, Jr. of Atlanta has been granted a Fellowship in the American College of Cardiology and was included in a group of 94 from the United States and Canada recently admitted.

New chief of staff at Northside Hospital is **Robert Van de Wetering** of Atlanta who is assistant professor of psychiatry at Emory University. Dr. "Van" is a Washington state native who attended the University of Tennessee Medical School. He has served on the board of directors of Blue Shield, the medical board of Family and Children Services and as alternate director of the Georgia Medical Care Foundation.

Sixth District

Hugh K. Sealy of Macon is one of 94 doctors in the country recently granted Fellowships in the American College of Cardiology after fulfilling requirements concerning years of practice and specialty certification.

Seventh District

Virginia Hamilton, who has been acting director of the Metro West health district headquartered in Marietta since July, 1971, has resigned to accept a similar post with the Coosa Valley Health District in Rome covering 10 counties. She is a graduate of Medical College of Alabama and has advanced degrees in health administration from the University of North Carolina.

Robert D. Walter of Calhoun has been appointed to the Mead Johnson Awards Committee of the American Academy of Family Physicians and will serve for one year.

DEATHS

William Shelly Cook

William Shelly Cook of Albany died December 23 at the age of 88.

The Alabama native was graduated with honors from Atlanta College of Physicians and Surgeons (now Emory University) in 1907 and began his practice in Albany two years later, retiring in 1957 from service that took him to many surrounding communities to answer calls.

In addition to professional memberships in Dougherty County Medical Society, the American Medical Association and the American Association of Railway Surgeons, he was a Kiwanian, Mason and Shriner.

Dr. Cook is survived by his widow, the former Fay Edgerly of Albany; daughter, Mrs. Glen Port of Albany; son, W. Shelley Cook of Demopolis, Ala.; one sister; several grandchildren.

Claude W. Harvey

Hogansville physician Claude W. Harvey, 88, died December 25 in City-County Hospital in LaGrange.

During the 50 years that Dr. Harvey practiced medicine in Hogansville, he was active also in community and church, serving as mayor, member of the board of directors of two banks, president of the Kiwanis Club and steward of the First Methodist Church.

Survivors include his widow, Mrs. Iva Anderson Harvey; daughter, Mrs. E. M. Darden of Hogansville; sister, Mrs. L. M. Huey; and brother, James H. Harvey, both of Shreveport, La.

Thomas E. McGeachy

Former president of the Emory University Hospital staff, Thomas E. McGeachy, 67, died January 5 of cancer.

Dr. McGeachy was born in Decatur, graduated from Davidson College and Emory University School of Medicine. He interned at Grady Memorial Hospital. During World War II he served in the U. S. Navy Medical Corp and was awarded a presidential citation for his performance during the assault on Iwo Jima.

A former president of the DeKalb County and Fifth District medical societies, Dr. McGeachy was also a member of the Decatur Rotary Club.

Among the survivors are his widow, Mrs. Frances Fletcher McGeachy; daughters, Mrs. Norman D. McCutcheon of Atlanta and Mrs. Walter A. Reeves, Jr. of Decatur; brother, the Rev. Neill R. McGeachy of Statesville, N. C.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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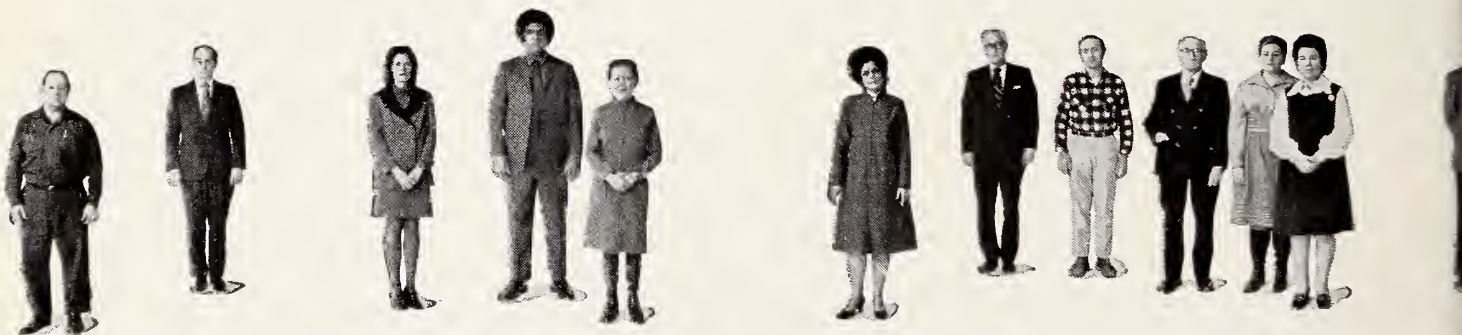
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Warnings: Tolerance usually develops within a few weeks. When it occurs, the recommended dosage should not be exceeded in an attempt to increase anorectic effect.

Drug Dependence: Tolerance and extreme psychological dependence have occurred. Patients have been known to increase dosage of drugs of this type to many times the recommended dosage. Abrupt cessation following prolonged high dosage results in extreme fatigue, mental depression, and reversible changes in the sleep EEG. Manifestations of chronic intoxication include severe dermatoses, marked insomnia, irritability, hyperactivity and personality changes. The most severe manifestation is psychosis, often clinically indistinguishable from schizophrenia.

Caution patients on the possibility of impaired ability to operate machinery or drive a motor vehicle or engage in other potentially hazardous activity.

Use in Pregnancy: There have been clinical reports of congenital malformation associated with the use of this compound. A causal relationship has not been proved. Until more information is available, Preludin should not be used by women who are or may become pregnant, particularly in the first trimester, unless the physician feels potential benefits outweigh possible risks.

Use in Children: Not recommended for use in children under 12 years of age.

Precautions: Use with caution in patients with mild hypertension. Insulin requirements in diabetes mellitus may be altered. Association with anorectic agents and concomitant dietary regimen. Psychological disturbances may occur in some patients on a restrictive diet with or without concomitant use of an anorectic agent.

Adverse Reactions: Overstimulation, restlessness, insomnia, anxiety, headache, agitation, flushing, tremor, sweating, dizziness,

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Deaths	13A

Cover

Part of the charm Augusta offers as the site of the 1973 MAG Annual Session is the Old Medical College Building at the corner of Telfair and Sixth Streets which is included in the National Register of Historic Places. Completed in 1838 and used by the Medical College until 1917, the structure now serves as the Augusta Garden Center. Layout by Atlanta artist Bob Hamill.

119th Annual Session Official Call

*Extended to All Officers and Members
of the Medical Association of Georgia*

WELCOME TO THE 119TH ANNUAL SESSION of the Medical Association of Georgia to be held in Augusta, on May 10-13, 1973.

General Sessions

The opening session will be called to order by F. W. Dowda, M.D., Atlanta, President of the Medical Association of Georgia, at 9 a.m., Friday, May 11, in the Embassy Room, of the Richmond Motor Hotel, with the Presentation of Colors and a rendition of the National Anthem by Mrs. John Bates, president-elect, Woman's Auxiliary to the Medical Association of Georgia, accompanied by Mrs. Theo G. Chevaos, Augusta. A welcome by the Richmond County Medical Society President, Luther M. Thomas, Jr., M.D., will be followed by a welcome to Augusta by Mayor Lewis Newman. A special program of music will then be rendered by the Augusta College Choir. Reports from the Woman's Auxiliary and the Georgia Student American Medical Association Chapter Presidents will follow. The President-Elect's address will be a feature of this session.

The Final General Session on Sunday, May 13, at 9 a.m., features a religious observance with a Memorial Service to honor the members of the Medical Association of Georgia and the Woman's Auxiliary to the Medical Association of Georgia. The presentation of the Certificates of Appreciation, Life and 50 Year Membership Certificates and the Distinguished Service Award are included in this Final Session. The drawing of the name of the winner of the Commercial Exhibit Visitation Award will be held at this time and there will be an announcement of the site of the 1981 and 1982 Annual Sessions. Immediately following the adjournment of the Second Session of the MAG House of Delegates, the Final Session will reconvene for installation of officers and adjournment of the 119th Annual Session.

Calhoun Lectureship

It will be the privilege of the membership to hear James W. Turpin, M.D., founder and international

director of Project Concern, speaking on "Before The First Shot—" for the lectureship presentation.

General Meetings

On Friday afternoon a panel on "Is There a Crisis in American Medicine?" will be presented with Raymond Robillard, M.D., Montreal, Canada, president, Federation of Medical Specialists; Mr. A. J. Vogl, executive editor of "Medical Economics," Oradell, New Jersey; and Walter McClure, M.D., Minneapolis, Minnesota, of the Interstudy Organization.

Saturday's panel on "Medical-Legal Problems" will include Geoffrey T. Mann, M.D., chief medical examiner, Broward County, Dania, Florida and Sidney B. Weinberg, M.D., of New York, chief medical examiner for Suffolk County, New York and professor of forensic pathology, New York State University. Presiding at this session will be Dr. Herman D. Jones of Atlanta, an honorary member of the Medical Association of Georgia, and now retired director of the State Crime Laboratory.

Registration

A general registration desk for all will be open in the Richmond Motor Hotel on Thursday, May 10, from 8:30 a.m. to 5 p.m.; on Friday and Saturday from 8 a.m. to 5 p.m.; and on Sunday from 8 a.m. to 12 noon. *Admissions to meetings and to exhibits will be by registration badge only.*

Council

The MAG Executive Committee of Council will meet at 10 a.m. Wednesday, May 9, in the Georgian Room of the Richmond Motor Hotel. The Council Meeting is scheduled for 2 p.m. in the same room. There will also be an organizational meeting of Council held following the adjournment of the Annual Session on Sunday, May 13, in the Embassy Room.

Reference Committees

All members are invited to appear before the Reference Committees of the MAG House of Del-

legates on any business being considered by the House. Reference Committees will meet from 9 a.m. to 12 noon, Saturday, May 12, in assigned rooms at the Richmond Motor Hotel.

House of Delegates

The first session of the House of Delegates will convene on Friday, May 11, at 9 a.m. in the Embassy Room of the Richmond Motor Hotel, immediately following the First General Session. At this time nominations of the MAG officers will be made. At the invitation of the Association, John R. Kernodle, M.D., of Burlington, N. C., chairman of the AMA Board of Trustees, will address the House of Delegates on "AMA Priorities and Duties of Official Delegates." The second meeting of the House of Delegates will be convened on Sunday, May 13, in the same location at 9 a.m. for the hearing of Reference Committee reports. House actions and voting for MAG Officers will take place during this Session.

Medicine and Religion Breakfast

For the second year the MAG Committee on Medicine and Religion, under the chairmanship of W. H. Pool, M.D., of Augusta, will sponsor a program and breakfast at 7:30 a.m. Sunday, May 13, in the Georgian Room of the Richmond Motor Hotel. A discussion on "The Role of the Humanities Department of the Medical College of Georgia" will be heard, with Russell Moores, M.D., associate dean of curriculum, Father Daniel Munn, assistant professor, Department of Education, Research and Development, and Mr. Richard Martin, associate professor of humanities, as speakers. Also on the program will be a discussion entitled "What I Would Like to Have Learned" featuring John B. O'Neal, III, M.D. and Drayton Sanders, M.D. This breakfast is open to all who are interested and has been scheduled to accommodate the officers and delegates prior to the opening of the last session. Tickets for this event will be on sale at the registration desk.

50 Year and Life Members

Physicians to be awarded life membership and those who have practiced medicine for 50 years will be honored at the Final General Session, Sunday, May 13, at 9 a.m., in the Embassy Room of the Richmond Motor Hotel.

Life Members

Herbert S. Alden	Atlanta
H. C. Atkinson	Macon
D. L. Burns	Valdosta
Amey Chappell	Atlanta
Gordon Chason	Bainbridge
C. E. Cunningham	Decatur
Feltz C. Davis	Macon
George R. Dillinger	Thomasville
G. A. Duncan	Decatur

Edgar M. Dunstan	Decatur
Walter C. Earle	Atlanta
W. G. Elliott	Cuthbert
Thomas P. Findley	Atlanta
Major F. Fowler	Atlanta
R. M. Harbin, Jr.	Romney
A. Worth Hobby	Atlanta
John C. Ivey	Clarkston
Montero Y. Levy	Atlanta
B. G. Owens	Valdosta
Edgar R. Pund	Seneca, S. C.
David E. Quinn	Dublin
Leonard J. Rabhan	Marathon, Fla.
Joseph C. Read	Atlanta
J. Harry Rogers	Atlanta
Samuel F. Rosen	Savanna
Fred F. Rudder	Atlanta
Cyrus H. Stoner	Atlanta
D. O. Thompson	Atlanta
D. Lloyd Wood	Dalton
Edward S. Wright	Atlanta
George W. Wright	Augusta

50 Year Members

John L. Elliott	Savanna
Lauren H. Goldsmith	Athena
Marion A. Hubert	Athena
Clinton G. Kemper	Atlanta
William V. Long	Savanna
James C. Metts	Savanna
Robert M. Paty	Oxford
Irvine Phinizy	Augusta

Memorial Service

The Association will hold the traditional Annual Memorial Service at the Final General Session Sunday morning, May 13, in the Embassy Room of the Richmond Motor Hotel. At the request of the Auxiliary, for the first time a combined service will be held this year with the reading of the names of the deceased members in each of the organizations. This event will honor and recall the service and contributions of those deceased members in the past year.

MAG Deceased Members

Alfred M. Battey, Augusta, Jan. 18, 1973
Charles R. F. Beall, Atlanta, July 12, 1972
Edgar Boling, Atlanta, July 28, 1972
Robert A. Clark, Jr., Macon, March 6, 1973
W. S. Cook, Albany, Dec. 23, 1972
H. L. Dismuke, Ocilla, Jan. 30, 1973
M. T. Edgerton, Atlanta, June 2, 1972
John Davis Elder, Athens, March 5, 1973
F. N. Gibson, Thomson, Nov. 1971
Henry W. Grady, Columbus, May 9, 1972
C. W. Harvey, Hogansville, Dec. 25, 1972
Charles W. Hock, Augusta, June 11, 1972
L. W. Kaul, Athens, July 4, 1972
Joseph E. Lever, Sandersville, Nov. 13, 1972
Charles G. Luther, Jr., Augusta, Feb. 7, 1972
Thomas E. McGeacy, Decatur, Jan. 5, 1973
Floyd W. McRae, Atlanta, Aug. 28, 1972
W. E. Matthews, Augusta, June 18, 1972
J. Hubert Milford, Hartwell, Oct. 26, 1972
John W. Mobley, Thomasville, May 17, 1972

D. F. Mullins, Augusta, Feb. 2, 1973
 Emory R. Park, LaGrange, July 1, 1972
 William M. Pavlovsky, Atlanta, June 4, 1972
 R. C. Pendergrass, Americus, Nov. 11, 1972
 E. A. Rosen, Dalton, Oct. 22, 1972
 Leonard R. Rue, Atlanta, July 11, 1972
 S. C. Rutland, Atlanta, July 2, 1972
 H. Ansley Seaman, Waycross, May 26, 1972
 Richard C. Shepard, Jr., LaFayette, June 10, 1972
 John N. Sherouse, Lavonia, June 16, 1972
 J. G. Standifer, Blakely, Nov. 20, 1972
 Oscar R. Styles, Sr., Cedartown, April 24, 1972
 Dallas Norman Thompson, Elberton, Jan. 27, 1973
 J. T. Vansant, Villa Rica, Nov. 24, 1972
 C. D. Vinson, Lizella, Sept. 8, 1972
 R. A. Vonderlehr, Atlanta, Jan. 28, 1973
 C. B. Welch, Attapulcus, June 27, 1972
 J. N. Willis, Columbus, Aug. 12, 1972
 Leonard W. Willis, Sr., Bainbridge, May 28, 1972

Auxiliary Deceased Members

Mrs. W. Devereaux Jarratt, Macon
 Mrs. George Hall, Roswell
 Mrs. J. Lon King, Macon (Past President WAMAG)
 Mrs. William H. Lippitt, Savannah
 Mrs. Glenn McCormick, Atlanta
 Mrs. Robert C. McGahee, Augusta
 Mrs. Charles L. Ridley, Macon
 Mrs. David C. Williams, Macon

MAG Message Center

A message center will be maintained near the MAG official registration desk for the convenience of the membership. Pages from the Woman's Auxiliary to the Medical Association of Georgia will staff this message center during the entire Session for incoming messages only. A bulletin board at this center will be available for notices of special importance during the Annual Session.

MAG Headquarters Office and News Room

The Association staff will maintain a headquarters office in the Oak Room of the Richmond Motor Hotel.

An MAG news room will be available adjacent to the registration desk in the second floor motor inn lobby area for newspaper, radio and television personnel.

Hotel Reservations

Officers, councilors, delegates, and special out-of-state guest speakers will be housed in a reserved block of rooms at the Richmond Motor Hotel. Special reservation forms will be issued to the above by the MAG headquarters office. The other motels holding rooms for the Annual Session are listed on the reservation page of the *Journal-MAG*. Please request accommodations directly to the motel of your choice.

Elections

The nominations of officers of the Association, AMA delegates and alternates, as well as the an-

nouncement of the Family Physician of the Year, will be the order of business in the First Session of the House of Delegates Friday, May 11. Delegates at the Second Session of the House on Sunday will elect the officers, AMA delegates and alternates, with installation at the Final General Session immediately following the adjournment of the House of Delegates. The Delegates Handbook will list the position vacancies.

Specialty Society Meetings and Social Events

The Specialty Societies have planned meetings, both business and scientific, luncheons, receptions and dinners, for the membership of their organizations to be held in conjunction with the Annual Session. These events are listed in the Official Program under the heading of "Specialty Society Meetings and Social Events" with the date, time and location of the event.

Richmond County Medical Society Social Hour

The host society invites the membership and their wives to be its guests for cocktails on Saturday evening, May 12, from 6:30 p.m. to 8:00 p.m. preceding the Annual Banquet. The affair will be held on the Pool Terrace (weather permitting) or in the Georgian Room, Richmond Motor Hotel.

Annual Banquet

The Association will honor its president at the traditional Annual Banquet to be held at 8 p.m. Saturday evening, May 12. It will begin after the Richmond County Medical Society Social Hour in the Embassy Room of the Richmond Motor Hotel. The incoming president is installed and awards are made at this time. Delightful entertainment is planned for this banquet with a performance by the "Wits End Players" of Atlanta. The Hardman and Civic Endeavor Awards, the Scientific and Special Activities Awards will be presented at this time. Prizes for the Art Show will also be presented. Dress will be semi-formal.

Alumni Events

The alumni receptions and dinners of the two Georgia medical schools as well as other medical alumni class reunions will be held Friday, May 11. Other medical alumni events are listed in the Official Program under this heading.

Athletic Events

The annual MAG golf tournament will be held at the Westlake Country Club Thursday and Friday, May 10-11. Westlake is a relatively new course, but is in excellent condition and the chairman urges you to bring your golf clubs and enjoy a nice round. No tee times will be necessary and you may either make your own game or one will be arranged for

you. Inquiries may be directed to: Steve Mulherin, M.D., 1527 Gwinnett Street, Augusta, Ga. 30904.

Arrangements have been made for the tennis tournaments to be held at 2 p.m. Thursday afternoon, May 10, for the men and at 10 a.m. Friday, May 11, for the women at the Augusta Country Club on Milledge Road. Entry fee is \$1 per person. For further information please contact: Ronald F. Galloway, M.D., 1407-D Gwinnett Street, Augusta, Ga. 30904 (men's tournament); and Lois T. Ellison, M.D., Medical College of Georgia, Augusta, Ga. 30902, for the ladies' tournament.

Medical Mile

The Medical Mile is scheduled for 5 p.m. Friday, May 11 at the Richmond Academy Track which is one mile out from University Hospital on Walton Way. Please contact: Daniel F. Ward, M.D., 1467 Harper Street, Augusta, Ga. 30902, for further information.

Art Show

The Art Show special feature improves with each Annual Session. In May the exhibits will be on display in the Hallway of the Second Floor Motor Inn Lobby near the Registration Desk. Prizes will be given for the First, Second and Third Place winners plus a prize for the "Honorable Mention" exhibit. Mrs. William A. Fuller, Augusta, is Chairman this year and you may contact her if you have an entry. Please note the entry form published in this issue of the *Journal-MAG*.

GaMPAC

The Georgia Medical Political Action Committee will hold its breakfast for the Board of Directors in the Teakwood Room of the Richmond Motor Hotel 7:30 a.m. Friday, May 11.

Scientific Exhibits

The Scientific Exhibits will be displayed in the same area as the Commercial Exhibits with the exhibit hall made up of the French, Spanish, and Italian Rooms of the Richmond Motor Hotel. These exhibits are prepared by physicians who will be present to discuss their displays with the membership. Awards for outstanding research will be presented at the Annual Banquet.

Commercial Exhibits

Approximately 35 exhibits will be displayed in the Richmond Motor Hotel. These have been floor-planned by the decorating company with the easy flow of traffic in mind. Your visitation to the Commercial and Scientific Exhibits is important and another prize will be offered this year. The Commercial Exhibits play an extremely important role in making the Annual Session possible through their support of the meeting. It is urged that you visit these exhibits.

Commercial Exhibitors

Booth No.	Name of Firm
1	Stuart Pharmaceuticals, Wilmington, Del.
2	Ortho Pharmaceuticals, Raritan, N. J.
3	William P. Poythress & Company, Inc., Richmond, Va.
4	Schering Laboratories, Kenilworth, N. J.
5	Riker Laboratories, Inc., Northridge, Calif.
6	ICI America Inc., Wilmington, Del.
7	Coca-Cola Co., Atlanta, Ga.
9	Thomson & McKinnon Auchincloss Inc., Atlanta, Ga.
11	Blue Shield, Atlanta and Columbus, Columbus, Ga.
12	Eli Lilly and Company, Indianapolis, Ind.
13	Nationwide Pension Planning, Atlanta, Ga.
14	Pitney-Bowes, Inc., Atlanta, Ga.
15	Pitney-Bowes, Inc., Atlanta, Ga.
17	Astra Pharmaceuticals, Worcester, Mass.
18	Pfizer Laboratories, Doraville, Ga.
19	Dictaphone Corporation, Rye, N. Y.
20	A. H. Robins Company, Richmond, Va.
23	Shearson-Hamil Co., Atlanta, Ga.
27	American Massage, Inc., Lighthouse Point, Fla.
28	Life Insurance Company of Georgia, Atlanta, Ga.
29	Sandoz Pharmaceuticals, Hanover, N. J.
30	Mead Johnson Laboratories, Evansville, Ind.
31	Office Communications, Inc., Atlanta, Ga.
32	Searle Laboratories, Chicago, Ill.
33	Miller Pharmacal Company, West Chicago, Ill.
34	Ayerst Laboratories, New York, N. Y.
35	Dow Chemical Company, Indianapolis, Ind.

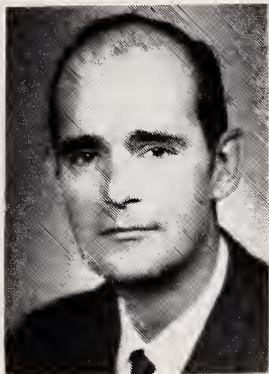
Commercial Contributions

Eli Lilly and Company, Indianapolis, Ind.
Geigy Pharmaceuticals, Summit, N.J.
A. H. Robins Company, Richmond, Va.
Merck Sharp and Dohme, West Point, Pa.

Grants from the above pharmaceutical houses are acknowledged with appreciation.

1972-1973

OFFICERS AND COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA



F. W. Dowda
President



C. E. Bohler
President-Elect



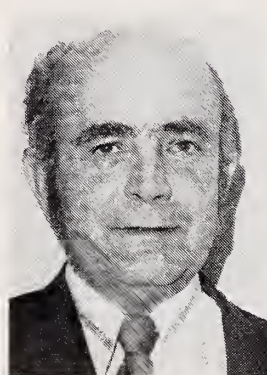
Braswell E. Collins
First Vice President



Earnest C. Atkins
Secretary



Carson B. Burgstiner
Treasurer



David A. Wells
Chairman of Council



H. Hilt Hammett
Second Vice President

OFFICERS

President—F. W. Dowda, Atlanta (1973)*
 President-Elect—C. E. Bohler, Brooklet (1973)*
 Immediate Past President—W. C. Mitchell, Smyrna (1975)*
 Past President—F. G. Eldridge, Valdosta (1974)
 Past President—John Kirk Train, Savannah (1973)
 First Vice President—Braswell E. Collins, Macon (1973)*
 Second Vice President—H. Hilt Hammett, LaGrange (1973)*
 Chairman of Council—David A. Wells, Dalton (1973)*
 Secretary—Earnest C. Atkins, Atlanta (1975)*
 Treasurer—Carson B. Burgstiner, Savannah (1975)*
 Speaker of the House—Harrison L. Rogers, Atlanta (1974)*
 Vice Speaker of the House—John Rhodes Haverty, Atlanta (1974)*
 Chairman of Finance Committee—F. G. Eldridge, Valdosta (1973)*
 Editor JMAG—Edgar Woody, Jr., Atlanta (1973)

* Executive Committee

COUNCILORS

District:

- 1—C. E. Bohler, Brooklet (1973)
- 2—J. D. Bateman, Albany (1973)
- 3—J. T. Christmas, Vienna (1973)
- 6—W. E. Barron, Newnan (1974)
- 7—David A. Wells, Dalton (1974)
- 8—Robert E. Perry, Jr., Brunswick (1974)
- 9—Paul T. Scoggins, Commerce (1975)
- 10—Edwin W. Allen, Jr., Milledgeville (1975)

Bibb County Medical Society

Braswell E. Collins, Macon (1975)

Cobb County Medical Society

Remer Y. Clark, Marietta (1975)

DeKalb County Medical Society

L. C. Buchanan, Decatur (1975)

Medical Association of Atlanta

Fleming L. Jolley, Atlanta (1975)

J. Harold Harrison, Atlanta (1973)

John T. Godwin, Atlanta (1974)

Georgia Medical Society

L. R. Lanier, Jr., Savannah (1973)

Muscogee County Medical Society

Jack A. Raines, Columbus (1974)

Richmond County Medical Society

Ronald F. Galloway, Augusta (1975)

VICE COUNCILORS

District:

- 1—Albert M. Deal, Statesboro (1973)
- 2—Frank R. Miller, Thomasville (1973)
- 3—John H. Robinson, Americus (1973)
- 6—Norman P. Gardner, Thomaston (1974)
- 7—Don Schmidt, Cedartown (1974)
- 8—Joe C. Stubbs, Valdosta (1974)
- 9—Robert S. Tether, Gainesville (1975)
- 10—M. A. Hubert, Athens (1975)

Milton I. Johnson, Macon (1975)

Charles R. Underwood, Marietta (1975)

Luther M. Vinton, Avondale Estates (1975)

T. J. Anderson, Jr., Atlanta (1975)

W. W. Moore, Jr., Atlanta (1973)

J. Norman Berry, Sandy Springs (1974)

L. S. Bodziner, Savannah (1973)

Louis A. Hazouri, Columbus (1974)

Henry D. Scoggins, Augusta (1975)

DELEGATES TO AMA AS OF JANUARY 1, 1973

<i>Delegates</i>	<i>Term Ending</i>
J. W. Chambers, LaGrange	(12-31-73)
John S. Atwater, Atlanta	(12-31-73)
J. Frank Walker, Atlanta	(12-31-74)
Preston D. Ellington, Augusta	(12-31-74)

<i>Alternate Delegates</i>	
F. G. Eldridge, Valdosta	(12-31-73)
Henry S. Jennings, Gainesville	(12-31-73)
J. D. Bateman, Albany	(12-31-74)
F. W. Dowda, Atlanta	(12-31-74)

CALL FOR SCIENTIFIC EXHIBITS

119TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

AUGUSTA, GEORGIA, MAY 10-13, 1973

For Information and Applications, Write:

**John McClure, Jr., M.D., Chairman,
MAG Scientific Exhibits Committee**

**Attention: Mrs. Catherine L. Wooten
938 Peachtree Street, N.E., Atlanta, Georgia 30309**

OFFICIAL PROGRAM

THURSDAY, MAY 10

- 8:30 General and Delegates Registration**
Second Floor Motor Lobby, Richmond Motor Hotel
- 9:00 View Exhibits**
- 9:00 Specialty Society Meetings and Lunches**
- 5:00** *(See Specialty Society Meetings and Social Events Section)*
- 6:30 Specialty Society Receptions and Dinners**
(See Specialty Society Meetings and Social Events Section)

FRIDAY, MAY 11

- 8:00 General and Delegates Registration**
Second Floor Motor Lobby, Richmond Motor Hotel
- 8:30 View Exhibits**
- 9:00 First General Session**
Presiding
F. W. Dowda, M.D., Atlanta, President,
Medical Association of Georgia
Call to Order
Invocation
Rev. Samuel W. Edleman, Jr., St. Paul's
Episcopal Church, Augusta
Presentation of Colors
Fort Gordon Color Guard
National Anthem
Mrs. John G. Bates, Cuthbert, President-Elect, WAMAG, Soloist
Mrs. Theo G. Thevaos, Augusta, Accompanist
Welcome
Luther M. Thomas, Jr., M.D., Augusta, President, Richmond County Medical Society
Greetings
Honorable Lewis Newman, Mayor, City of Augusta
Introduction of Distinguished Guests
Special Program
Augusta College Choir
Report of President of Woman's Auxiliary
Mrs. Cliff Moore, Jr., Rome, President, Woman's Auxiliary to the Medical Association of Georgia

Greetings From the President-Elect of the Woman's Auxiliary to the AMA

Mrs. Willard C. Scrivner, East St. Louis, Ill.

Report of Presidents of Georgia Student American Medical Association Chapters

Mr. Blane Crandall, President, Emory University School of Medicine SAMA Chapter, Atlanta

Mr. Charles Green, President, Medical College of Georgia SAMA Chapter, Augusta

President-Elect's Address

C. E. Bohler, M.D., Brooklet, President-Elect, Medical Association of Georgia

Announcements

Recess

11:00 First Session, House of Delegates Presiding

Harrison L. Rogers, M.D., Atlanta, Speaker

Nominations of Officers of MAG, AMA Delegates and Alternates

Announcement of Family Physician of the Year and Award Presentation

Introduction of Business

Speaker

John R. Kernodle, M.D., Burlington, N. C., Chairman, AMA Board of Trustees

Announcements

Recess

12:00 Abner W. Calhoun Lectureship Presiding

F. W. Dowda, M.D., Atlanta, President, Medical Association of Georgia

"Before the First Shot . . ."

James W. Turpin, M.D., Founder and International Director of Project Concern, San Diego, Calif.

1:00 View Exhibits

2:00 General Meeting

(All Physicians, Auxiliary Members and Guests Invited)

Embassy Room, Richmond Motor Hotel

"Is There a Crisis in American Medicine?"

Moderator

H. Hilt Hammett, M.D., LaGrange, Second Vice President, Medical Association of Georgia

Panelists

Raymond Robillard, M.D., Montreal,
Canada, President, Federation of
Medical Specialists
Mr. A. J. Vogl, Oradell, N. J., Execu-
tive Editor, *Medical Economics*
Walter McClure, M.D., Minneapolis,
Minn., Interstudy Organization

5:00 View Exhibits

6:30 Alumni Receptions and Dinners
(See Alumni Events Section)

SATURDAY, MAY 12

8:00 General and Delegates Registration
*Second Floor Motor Lobby, Richmond
Motor Hotel*

8:30 View Exhibits

9:00 Reference Committee Meetings
Richmond Motor Hotel

2:00 General Meeting
(All Physicians, Auxiliary Members and
Guests Invited)
Embassy Room, Richmond Motor Hotel
"Medical-Legal Problems"

Moderator

Dr. Herman Jones, Atlanta, Former Di-
rector State Crime Laboratory

Panelists

Geoffrey T. Mann, M.D., Dania, Fla.,
Chief Medical Examiner of Broward
County
Sidney B. Weinberg, M.D., Huntington
Station, N. Y., Chief Medical Ex-
aminer of Suffolk County

5:00 View Exhibits

**6:30 Richmond County Medical Society So-
cial Hour**
(All MAG Members, their Wives and Ex-
hibitors Invited)
*Pool Terrace/Georgian Room, Richmond
Motor Hotel*

8:00 Annual Banquet
Embassy Room, Richmond Motor Hotel
Presiding

F. W. Dowda, M.D., Atlanta, President,
Medical Association of Georgia

Presentation of Awards:

Special Activities Awards—Golf, Ten-
nis, Art and Medical Mile
Scientific Exhibits Awards
Hardman Award
Civic Endeavor Award

Inauguration of President of the Medi- cal Association of Georgia Entertainment

SUNDAY, MAY 13

7:30 Medicine and Religion Breakfast
Georgian Room, Richmond Motor Hotel
Presiding

W. H. Pool, M.D., Augusta

**"The Role of the Humanities Depart-
ment at the Medical College of Georgia"**

Russell Moores, M.D., Augusta

Father Daniel Munn, Augusta

Mr. Richard Martin, Augusta

"What I Would Like to Have Learned"

John B. O'Neal, III, M.D., Elberton

Drayton M. Sanders, M.D., Dalton

8:00 General and Delegates Registration
*Second Floor Motor Lobby, Richmond
Motor Hotel*

8:30 View Exhibits

9:00 Second (Final) General Session
(All Physicians, Auxiliary Members and
Guests Invited)
Embassy Room, Richmond Motor Hotel
Presiding

F. W. Dowda, M.D., Atlanta, President,
Medical Association of Georgia

Call to Order

Religious Observance

Rabbi Norman M. Goldberg, Augusta

Memorial Service (MAG and Auxiliary)

Rabbi Norman M. Goldberg, Augusta

Presentation of Certificates of Apprecia- tion

Earnest C. Atkins, M.D., Atlanta, Sec-
retary, Medical Association of Geor-
gia

Presentation of Life Membership Cer- tificates

H. Hilt Hammett, M.D., LaGrange, Sec-
ond Vice President, Medical Associa-
tion of Georgia

Presentation of 50 Year Membership Certificates

Braswell E. Collins, M.D., Macon, First
Vice President, Medical Association
of Georgia

Presentation of Distinguished Service Award

F. W. Dowda, M.D., Atlanta, President,
Medical Association of Georgia

Announcement of Site for 1981 and 1982 Annual Sessions

Recess

10:00 Second Session, House of Delegates
Presiding
Harrison L. Rogers, M.D., Atlanta,
Speaker
Election of MAG Officers, AMA Del-
egates and Alternates
Reference Committee Reports
Announcements
Adjournment of House of Delegates

12:00 Second (Final) General Session
(Reconvened)
Presiding
F. W. Dowda, M.D., Atlanta, President,
Medical Association of Georgia
Installation of Officers
Announcements
Commercial Exhibit Visitation Drawing
Adjournment of 119th Annual Session

MEDICAL ASSOCIATION OF GEORGIA PRESENTS
5TH ANNUAL ART SHOW
RICHMOND MOTOR HOTEL, AUGUSTA, GEORGIA

Entries:

Each artist is limited to 3 entries. On the back of each place a 3" x 5" card with your name, address, title of exhibit and selling price. All entries must be ruled acceptable before being hung. Work must be original. Art work that has won previously will be excluded. Sales are encouraged with a 20 per cent commission charged to benefit AMA-ERF.

Categories:

(1) Paintings—including watercolor, oil, and mixed media, framed and ready for hanging.

- (2) Photography—must be matted.
- (3) Sculpture
- (4) Arts and crafts

Judge:

Judging for appropriate prizes will be done Saturday morning. No one will be allowed in the judging area at this time.

All entries must be brought to the Richmond Motor Hotel Lobby (second floor) between 10 a.m. and 5 p.m. on Thursday and Friday, May 10 and 11, and picked up on Sunday by noon following adjournment of the Annual Session. Security guards will be on duty at all times.

1973 ART SHOW REGISTRATION CARD

Return to: Mrs. W. A. Fuller
2255 Overton Road
Augusta, Georgia 30904

Name

Address

City and State Zip

I plan to enter # ... entries.

My categories are as follows: (Indicate the number of each)

- (1) Paintings
- (2) Photography
- (3) Sculpture
- (4) Arts and crafts

ARTIST'S RECEIPT

NAME

ADDRESS

CITY AND STATE ZIP

ENTRIES

1. Title

Price

2. Title

Price

3. Title

Price

Representative's Signature

.....

Paintings must be picked up by
Sunday Noon, May 13, 1973

BRING THIS CARD WITH YOUR ENTRY!

SPECIALTY SOCIETY MEETINGS AND SOCIAL EVENTS

Specialty Society Program Chairmen

(Only those Specialty Societies having meetings are listed)

GEORGIA SOCIETY OF ANESTHESIOLOGISTS

H. H. Osborne, M.D., Medical College of Georgia, Augusta, 30902

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Ronald F. Galloway, M.D., 1407-D Gwinnett Street, Augusta, 30902

GEORGIA THORACIC SOCIETY

Lois T. Ellison, M.D., Medical College of Georgia, Augusta, 30902

GEORGIA TB-RD ASSOCIATION

Mr. Flay Sellers, Administrative Assistant, 1383 Spring Street, N.W., Atlanta, 30309

GEORGIA SOCIETY OF DERMATOLOGISTS

Edward H. Smith, Jr., M.D., 905-A 15th Street, Augusta, 30901

GEORGIA DIABETES ASSOCIATION

T. A. Huff, M.D., Medical College of Georgia, Department of Medicine, Augusta, 30902

GEORGIA SOCIETY OF INTERNAL MEDICINE AND GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

W. N. Agostas, M.D., 1021 15th Street, Augusta, 30901

GEORGIA NEUROLOGICAL ASSOCIATION

George Mushet, M.D., 1467 Harper Street, Augusta 30902

GEORGIA NEUROSURGICAL SOCIETY

Marshall Allen, M.D., Medical College of Georgia, Augusta, 30902

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Paul McDonough, M.D., Department of OB-GYN, Medical College of Georgia, Augusta, 30902

Mr. Chester Lane, Executive Director, Georgia State Obstetrical and Gynecological Society, 69 Butler Street, S.E., Atlanta, 30303

GEORGIA SOCIETY OF OPHTHALMOLOGY

Robert Thomas, M.D., 1445 Harper Street, Augusta, 30902

Phinzy Calhoun, Jr., M.D., Emory University School of Medicine, 1365 Clifton Road, N.E., Atlanta, 30322

GEORGIA SOCIETY OF OTOLARYNGOLOGY

Joseph I. Gillespie, M.D., 810 13th Street, Augusta, 30902

GEORGIA ORTHOPEDIC SOCIETY

Nazir Bhatti, M.D., Medical College of Georgia, Augusta, 30902

GEORGIA ASSOCIATION OF PATHOLOGISTS

James L. O'Quinn, M.D., 1465 Harper Street, Augusta, 30902

GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

Daniel H. G. Glover, M.D., Richmond County Health Department, 1001 Bailie Drive, Augusta, 30902

GEORGIA RADIOLOGICAL SOCIETY

Mark Brown, M.D., Radiology Department, Talmadge Memorial Hospital, Augusta, 30902

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Daniel B. Sullivan, M.D., 1467 Harper Street, Augusta, 30902

GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Saturday, May 12

1:00 Scientific Meeting

Thunderbird Inn

Presiding: H. H. Osborne, M.D., Augusta
H. Turner Edmondson, M.D., Augusta: "The Importance of Expediting Operative Procedure in Major General Surgery"; Robert T. Whitehead, M.D., Augusta: "Anesthetic Management of Cardiac Patient for Emergency Surgery"; Margaret DeVore, M.D.,

Augusta: "Anesthetic Management of the Thyroid Patient for Emergency Surgery"; J. F. Johnston, M.D., Augusta: "Anesthetic Management of the Pulmonary Patient for Emergency Surgery."

7:00 Social Hour

Thunderbird Inn

Sunday, May 13

9:00 Question and Answer Session

Thunderbird Inn

10:00 Business Meeting

Thunderbird Inn

**GEORGIA CHAPTER, AMERICAN
COLLEGE OF CHEST PHYSICIANS,
GEORGIA THORACIC SOCIETY AND
GEORGIA TUBERCULOSIS-
RESPIRATORY DISEASE ASSOCIATION**

Thursday, May 10

- 9:00 Seminar: "A Perspective in Diagnostic Techniques in Pulmonary Disease"
Thunderbird Inn
Moderator: Robert G. Ellison, M.D., Augusta
James C. Crutcher, M.D., Atlanta: Introduction and Announcements; Thomas B. Ferguson, M.D., St. Louis, Mo.: "Mediastinal Exploratory Procedures in Diagnosis of Pulmonary Disease"; Thomas A. Neff, M.D., Denver, Colo.: "Lung and Pleural Biopsy and Needle Aspiration"; Adam Wanner, M.D., Miami, Fla.: "Applications of Bronchofiberscopy"; W. H. Pool, M.D., Augusta: "Role of the Radiologist in Diagnosis of Pulmonary Disease."
- 12:00 Luncheon Meeting
Thunderbird Inn
- 2:00 Seminar (continued)
Moderator: Roland H. Ingram, Jr., M.D., Atlanta
Adam Wanner, M.D., Miami, Fla.: "Usefulness of Tracheobronchial Secretions in the Diagnosis of Pulmonary Disease"; Betty B. Wray, M.D., Augusta: "Immunological Considerations in the Diagnosis of Pulmonary Disease"; and G. Michael Duffell, M.D., Atlanta: "Diagnostic Approach in the Patient with Pleural Effusion."

**GEORGIA SOCIETY OF
DERMATOLOGISTS**

Saturday, May 12

- 9:00 Scientific Meeting
Thunderbird Inn
Presiding: Frederick F. Hardin, M.D., Atlanta
Alexander A. Fisher, M.D., Woodside, Long Island, N. Y.: "Contactants of Current Interest"; Edgar B. Smith, M.D., Albuquerque, N. M.: "Sherlock Holmes and Dermatology"; Terrence J. Cook, M.D., Augusta: "Allergic Eczema—Crossroads of Allergy and Dermatology"; and Marshall Cohen, M.D., Atlanta: "Aspirin Ulcerations of the Palate Due to Prolonged Exposure to Aspergum."
- 12:30 Luncheon
Thunderbird Inn
- 2:00 Scientific Meeting
Thunderbird Inn
Presiding: Frederick F. Hardin, M.D., Atlanta
J. Graham Smith, M.D., Augusta: "The Metabolism of Burns"; Alexander A. Fisher, M.D., Woodside, Long Island, N. Y.: "The Use of Non-Sensitizing Substitutes in the

Management of Allergic Contact Dermatitis."

3:35 Business Meeting
Thunderbird Inn

GEORGIA DIABETES ASSOCIATION

Thursday, May 10

- 12:00 Scientific Meeting
Department of Medicine, Medical College of Georgia
Presiding: A. J. Bollet, M.D., Augusta
J. Stuart Soeldner, M.D., Boston, Mass.: "The Artificial Pancreas" (To Be Given at Grand Rounds, Department of Medicine, Medical College of Georgia)
- 1:30 Luncheon
Thunderbird Inn
- 3:00 Business Meeting
Walton Room, Richmond Motor Hotel
Presiding: L. Harvey Hamff, M.D., Atlanta

**GEORGIA SOCIETY OF INTERNAL
MEDICINE AND GEORGIA CHAPTER,
AMERICAN COLLEGE OF PHYSICIANS**

Thursday, May 10

- 4:00 Business Meeting
Teakwood Room A and B, Richmond Motor Hotel
Presiding: W. J. O'Shaughnessey, M.D., Macon and Edwin C. Evans, M.D., Atlanta

**GEORGIA NEUROLOGICAL
ASSOCIATION**

Saturday, May 12

- 3:00 Organizational Meeting
(Place to be announced)
Presiding: George Mushet, M.D., Augusta

GEORGIA NEUROSURGICAL SOCIETY

Sunday, May 13

- 9:30 Scientific Meeting
Thunderbird Inn
Presiding: Louis O. J. Manganiello, M.D., Augusta
Clifton L. Cannon, Jr., M.D., Savannah: "Atlanto-occipital Dislocation. Report of a Case and Review of the Literature"; David L. Kelly, Jr., M.D., Kenneth Lassiter, M.D. and Jack Smith, M.D., Winston-Salem, N. C.: "Effects of Local Hypothermia and Hyperbaric Oxygenation on Traumatic Paraplegia"; Thomas J. Croft, M.D., East Point: "Reversible Spinal Cord Trauma, A Model for Electrical Monitoring of Spinal Cord Function"; Mark A. Denaples, M.D., Augusta and Mr. Frederick L. Young, Augusta: "Cooling the Cervical Spinal Cord by the Anterior Approach—Using an Adaptation of the Cloward Technique for Fusing the Cervical Spine"; Samuel J. Hightower, M.D., Ma-

con, Robert A. Clark, M.D., Macon and Hugh F. Smisson, Jr., M.D., Macon: "A Series of 400 Cervical Disc Excisions With Interbody Fusion by the Smith-Robinson Technique"; Richard A. Smith, M.D., Atlanta: "Acute Reversible Transverse Myelopathy, Spinal Subdural Hematoma, and Neurofibroma."

11:30 Social Hour

Thunderbird Inn

12:00 Luncheon and Business Meeting

Thunderbird Inn

3:00 Scientific Meeting

Thunderbird Inn

R. Arthur Gindin, M.D., Augusta: "Undergraduate Instruction in the Neurological Sciences at the Medical College of Georgia"; Ellis B. Keener, M.D., Atlanta: "Dura Tentorial Anterior-Venous Malformations"; Gary E. Kaufmann, M.D., Atlanta and Kemp Clark, M.D., Atlanta: "Continuous Simultaneous Monitoring of Intraventricular and Cervical Subarachnoid Fluid Pressure to Indicate Development of Cerebellar Tonsillar Herniation"; Jay Osgood, M.D., Atlanta and Joe Williams, M.D., Atlanta: "Isolation of the Dog Brain Circulation at the Circle of Willis"; Haruyoshi Honda, M.D., Augusta, G. S. Doetsch, M.D., Augusta and Mr. Frederick L. Young, Augusta: "Recording C-Fiber Potentials in Peripheral Nerves"; Mark S. O'Brien, M.D., Atlanta: "Limited Ventriculography Using Water Soluble Positive Contrast. Experience With 100 Procedures in Children"; William W. Moore, Jr., M.D., Atlanta: "Simultaneous Differing Bilateral Brain Tumors"; William D. Lowery, Jr., M.D., Albany: "Some Observations on Cervical Disc Surgery."

6:30 Buffet

Host: Louis O. J. Manganiello, M.D.
656 Milledge Road, Augusta

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY AND GEORGIA ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

Wednesday, May 9

6:30 Georgia State Obstetrical and Gynecological Society Executive Committee and Committee Chairmen's Dinner

Boxwood Room A, Richmond Motor Hotel

Presiding: Darnell Brawner, M.D., Savannah

8:30 Georgia State Obstetrical and Gynecological Society Committee Meetings

(Rooms to Be Announced)

Thursday, May 10

8:30 Coffee

Georgian Room, Richmond Motor Hotel

9:00 Scientific Sessions

Georgian Room, Richmond Motor Hotel

Presiding: Darnell Brawner, M.D., Savannah

Moderator: Paul G. McDonough, M.D., Augusta

Dr. Wayne H. Finley, Birmingham, Ala.: "Sex Chromosome Aberrations"; Sara Finley, M.D., Birmingham, Ala.: "Single Gene Defects in Obstetrics/Gynecology"; Wayne H. Finley, M.D., Birmingham, Ala.: "Autosomal Aberrations"; Sara Finley, M.D., Birmingham, Ala.: "Prenatal Determination of Genetic Defects"; Rodney M. Browne, M.D., Macon: "Genetics Unit in a Community Hospital"; Case Presentations: Paul G. McDonough, M.D., Augusta; Discussion: Rodney M. Browne, M.D., Sara Finley, M.D., and Wayne H. Finley, M.D.

12:00 Luncheon and Business Meeting (Georgia State OB/GYN Society)

Kings Inn and Balcony, Richmond Motor Hotel

2:00 Scientific Sessions

Georgian Room, Richmond Motor Hotel

Presiding: Darnell Brawner, M.D., Savannah

Moderator: Preston L. Wilds, M.D., Augusta

Charles E. Flowers, M.D., Birmingham, Ala.: "Systemic Medication"; John D. Thomas, M.D., Charleston, S. C.: "Anesthesia for Maternal Complications of Pregnancy"; Charles E. Flowers, M.D., Birmingham, Ala.: "Conduction Anesthesia"; John D. Thomas, M.D., Charleston, S. C.: "Anesthesia for Cesarean Section"; William E. Barfield, Jr., M.D., Augusta: "A Resident's Perspective"; Case Presentation: Preston L. Wilds, M.D., Augusta; Discussion: William E. Barfield, Jr., M.D., Augusta; Charles E. Flowers, M.D., Birmingham, Ala.; and John D. Thomas, M.D., Charleston, S. C.

6:30 Social Hour

Pool Terrace, Richmond Motor Hotel

8:00 Banquet

Embassy Room, Richmond Motor Hotel

(For Georgia State Obstetrical and Gynecological Society Members, Reservations Required)

GEORGIA SOCIETY OF OPHTHALMOLOGY AND GEORGIA SOCIETY OF OTOLARYNGOLOGY

Saturday, May 12

12:00 Luncheon and Scientific Meeting

Kings Inn, Richmond Motor Hotel

Presiding: Robert P. Thomas, M.D., Augusta

Joseph I. Gillespie, M.D., Augusta

GEORGIA ORTHOPEDIC SOCIETY

Saturday, May 12

1:00 Lecture Symposium

Small Auditorium, Educational Building, Medical College of Georgia

Presiding: Nazier A. Bhatti, M.D., Augusta
Thomas E. Whitesides, Jr., M.D., Atlanta:

"Instability in Fracture of Lumbo-Dorsal Spines"; Sherman H. Blalock, M.D., Augusta: "Non-Operative Management of Fracture of Lumbo-Thoracic Spines"; Elwyn A. Saunders, M.D., Augusta: "Multiply Operated Back"; Joseph P. Bailey, Jr., M.D., Augusta: "Spine in Rheumatoid Arthritis"; Floyd E. Bliven, Jr., M.D., Augusta: "Tubercular and Non-Tubercular Infection of the Spine"; Thomas E. Whitesides, Jr., M.D., Atlanta: "Fractures and Dislocations of Cervical Spine"; Nazir A. Bhatti, M.D., Augusta: "Indications, Applications and Complications of Halo."

Display Demonstration—"Spinal Braces and Their Use."

- 6:30 Reception and Dinner
Residence of: James L. Becton, M.D.
806 Carriage Court, Augusta

GEORGIA ASSOCIATION OF PATHOLOGISTS

Thursday, May 10

- 1:00 Business Meeting
Fenwick Room, Richmond Motor Hotel
Presiding: Robert E. DeLashmutter, M.D., Atlanta
6:30 Social Hour and Dinner
Thunderbird Inn

GEORGIA RADIOLOGICAL SOCIETY

Thursday, May 10

- 8:00 p.m. Business Meeting
Thunderbird Inn
Presiding: J. H. Walker Harris, M.D., Columbus

Saturday, May 12

- 1:00 Business and Scientific Meeting
Thunderbird Inn
Presiding: Mark Brown, M.D., Augusta
David M. Witten, M.D., Birmingham, Ala.: "Uroradiographic Techniques: Changing Methods and Changing Concepts"; Herbert Brizel, M.D., Augusta: "Radiotherapy of Cervical Cancer—Old Hat and New Tricks"; William Carlton, Ph.D., Augusta: "Lacrimal Imaging"; W. H. Pool, Jr., M.D. and Zachary Kilpatrick, M.D. of Augusta: "Lymphogranuloma of the Colon (A New Look at an Old Problem)"; David M. Witten, M.D., Birmingham, Ala.: "Roentgenographic Observations in Renal and Perirenal Abscess"; Turner Ball, M.D., Atlanta: "Traumatic Diaphragmatic Hernia"; Patrick Peavy, M.D., Atlanta: "Metastatic Carcinoid Tumor to Bone—Two Distinctive Patterns"; David Hanes, M.D., Atlanta: "Radiographic and Isotopic Diagnosis of Cholelithiasis"; W. C. Lang, Jr., M.D., Atlanta: "The Radiographic Patterns of Soft Tissue Inflammatory Disease"; and Film

Panel, Moderator: Harry McGee, M.D., Savannah

- 7:00 Reception and Dinner
Pinnacle Club, Augusta

Sunday, May 13

- 8:00 Brunch
to Residence of: Mark Brown, M.D.
10:00 809 Windsor Court, Augusta

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Thursday, May 10

- 9:00 Scientific Meeting
Thunderbird Inn
Panel I: "Management of the Multiple Injured Patient"
Moderator: Carl Jelenko, III, M.D., Augusta
Panelists: Edward W. Berg, M.D., Augusta; Thomas Yeh, M.D., Savannah; Pomeroy Nichols, M.D., Augusta; Norman E. McSwain, M.D., Atlanta and C. R. F. Baker, Jr., M.D., Atlanta
Panel II: "Respiratory Problems After Trauma"
Moderator: Lloyd Rudy, M.D., Augusta
Panelists: Carl Jelenko, III, M.D., Augusta; Charles R. Wray, M.D., Augusta, Thomas Yeh, M.D., Savannah and Charles R. Hatcher, Jr., M.D., Atlanta

ALUMNI EVENTS

MEDICAL COLLEGE OF GEORGIA ALUMNI

Friday, May 11

- 6:30 Reception
Pool Terrace, Richmond Motor Hotel
8:00 Dinner
Embassy Room, Richmond Motor Hotel

EMORY UNIVERSITY SCHOOL OF MEDICINE ALUMNI

Friday, May 11

- 6:30 Reception
Thunderbird Inn
7:30 Dinner
Thunderbird Inn

MEDICAL COLLEGE OF GEORGIA, 1953 CLASS REUNION

Friday, May 11

- 6:00 Reception
Boxwood Room, Richmond Motor Hotel
Chairman: A. J. Greene, M.D., Augusta

MEDICAL COLLEGE OF GEORGIA, 1954 CLASS REUNION

Friday, May 11

- 6:00 Reception
Teakwood Room, Richmond Motor Hotel
Chairman: Henry Scoggins, M.D., Augusta

TULANE MEDICAL ALUMNI ASSOCIATION

Friday, May 11

7:00 Reception
Walton Room, Richmond Motor Hotel

MEDICAL COLLEGE OF GEORGIA, CLASS OF 1963—10TH REUNION

Saturday, May 12

7:00 Reception and Dinner
Thunderbird Inn
Chairman: Charles W. Linder, M.D., Augusta

OTHER EVENTS

GEORGIA MEDICAL POLITICAL ACTION COMMITTEE BOARD OF DIRECTORS MEETING

Friday, May 11

7:30 Breakfast and Meeting
Teakwood Room, Richmond Motor Hotel

MEDICINE AND RELIGION BREAKFAST

Sunday, May 13

7:30 Breakfast
Georgian Room, Richmond Motor Hotel

CRITERIA FOR SELECTION OF RECIPIENTS OF MAG AWARDS

HARDMAN CUP—This award is presented for “the achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery” or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented at the Annual Banquet, Saturday evening, May 12. By custom this award has usually gone to a Georgia physician. However, this is not required by the terms of the letter from Governor Hardman establishing this award.

DISTINGUISHED SERVICE—The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Sunday, May 13, 9:00 a.m., at the final General Session.

CIVIC ENDEAVOR AWARD—This award, presented for the first time at the 1969 Annual Session,

will be given pursuant to an action taken by the 1968 House of Delegates, in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters Office at least two weeks in advance of the Annual Session. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at the Annual Banquet, Saturday evening, May 12.

CERTIFICATES OF APPRECIATION—Recipients of Certificates of Appreciation will be selected jointly by the MAG Committee on Awards, Executive Committee and Council. These will be presented on Sunday, May 13, at 9:00 a.m., at the final General Session.

FAMILY PHYSICIAN OF THE YEAR (formerly GP OF THE YEAR)—This award is presented to an outstanding Family Physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the First Session of the House. The name of the Family Physician accompanied by supporting biographical data should be received at the MAG Headquarters Office by February 15 for inclusion in the Delegates Handbook. No nominations for this award may be made from the floor of the House. The President of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award at the First Session of the House.

Woman's Auxiliary to the Medical Association of Georgia 48TH ANNUAL CONVENTION

May 10-13, 1973 ★ Richmond Motor Hotel ★ Augusta



PRESIDENT'S GREETING

AS YOUR PRESIDENT, it is truly a great pleasure and privilege to welcome each of you to our 48th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Augusta, founded in 1735 by James Edward Oglethorpe, was named after the contemporary Princess of Wales. Augusta, being Georgia's second oldest city, is an exciting place for a convention, Southern Style. The Richmond County Medical Auxiliary has worked endlessly to make this a great convention for you.

"Communicate Contagious Space Age Culture"—a time to pass along our accomplishments in our past year's efforts and enjoy the fellowship.

Sincerely,
Mrs. Cliff Moore, Jr., *President*
Woman's Auxiliary to the
Medical Association of Georgia



WELCOME TO AUGUSTA

WELCOME TO AUGUSTA! We, the Woman's Auxiliary to the Richmond County Medical Society, invite you to help communicate our space age culture in this 48th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Our local convention chairman, Mrs. Stephen Mulherin, and auxiliary members have been planning months ahead for your arrival and anticipate much fun and excitement for all.

We look forward to an exchange of ideas plus sharing our city—a medical center, a golf capital, and a garden community whose old buildings testify to a rich historical background.

Come to Augusta where everyone smiles in the same language.

Mrs. Daniel Glover, *President*
Woman's Auxiliary to the
Richmond County Medical Society

THE PROGRAM

THURSDAY, MAY 10

- 9:00 Registration and Information**
to *Richmond Hall*
5:00 *Richmond Motor Hotel*
- 9:00 Art Show**
to *Second Floor Motor Lobby*
5:00 *Richmond Motor Hotel*
- 2:00 Hospitality**
to **Show and Tell Exhibits**
5:00 *Second Floor Motor Lobby*
Richmond Motor Hotel
- 2:00 Pre-Convention Executive Board**
to **Meeting**
4:00 *Boxwood Room*
Richmond Motor Hotel
- PRESIDING—Mrs. Cliff Moore, Jr.,
Rome, *President, Woman's Auxiliary to*
the Medical Association of Georgia
- INVOCATION—Mrs. Prentiss E. Parker,
Marietta, *President, Cobb County*
Medical Society
- PLEDGE OF LOYALTY AND COL-
LECT—Mrs. Robert M. Fine, Atlanta,
State Historian
- INTRODUCTION OF PAST PRESI-
DENTS—Mrs. A. Worth Hobby, At-
lanta, *Past President*
- 4:00 Adjournment**
- 4:30 Reception for 1972-73 and 1973-**
to **74 County Presidents, Presidents-**
5:30 Elect and State Chairmen
Walton Room
Richmond Motor Hotel

FRIDAY, MAY 11

- 9:00 Registration and Information**
to *Richmond Hall*
5:00 *Richmond Motor Hotel*
- 9:00 Art Show**
to *Second Floor Motor Lobby*
5:00 *Richmond Motor Hotel*
- 9:00 Hospitality**
to **Show and Tell Exhibits**
5:00 *Second Floor Motor Lobby*
Richmond Motor Hotel

- 9:00 MAG First General Session**
to *Embassy Room*
10:00 *Richmond Motor Hotel*

(All MAG and Auxiliary Members and
Guests Invited)

PRESIDING—F. W. Dowda, M.D., At-
lanta, *President, Medical Association of*
Georgia

NATIONAL ANTHEM—Mrs. John G.
Bates, Cuthbert, *President-Elect, Wo-*
man's Auxiliary to the Medical Associa-
tion of Georgia

REPORT OF WOMAN'S AUXILIARY
TO THE MEDICAL ASSOCIATION
OF GEORGIA—Mrs. Cliff Moore, Jr.,
Rome, *President*

GREETINGS FROM THE WOMAN'S
AUXILIARY TO THE AMERICAN
MEDICAL ASSOCIATION—Mrs.
Willard C. Scrivner, East St. Louis, Ill.,
President-Elect

- 10:00 Auxiliary General Meeting**
to *Georgian Room*
12:00 *Richmond Motor Hotel*

CALL TO ORDER—Mrs. Cliff Moore,
Jr., Rome, *President*

INVOCATION—Mrs. J. Hagan Baskin,
Atlanta, *President, Medical Association*
of Atlanta Medical Auxiliary

PLEDGE OF ALLEGIANCE TO FLAG
—Mrs. James G. Herron, Americus,
President, Sumter County Medical
Auxiliary

ADDRESS OF WELCOME—Mrs. Dan-
iel H. G. Glover, Augusta, *President,*
Richmond County Medical Auxiliary

RESPONSE TO WELCOME—Mrs. Rob-
ert S. McMichael, Macon, *President,*
Bibb County Medical Auxiliary

PRESENTATION OF CONVENTION
PLANS AND INTRODUCTION OF
PAGES FOR THE DAY—Mrs. Ste-
phen Mulherin, Augusta, *Convention*
Chairman

INTRODUCTION OF PAST PRESI-
DENTS AND GUESTS—Mrs. James
Hunt Manning, Marietta, *Past Presi-*
dent and Vice Councilor to Southern
Medical Association Auxiliary

Greetings

PRESIDENT OF MAG—F. W. Dowda, M.D., Atlanta

PRESIDENT-ELECT—C. Emory Bohler, M.D., Brooklet

INTRODUCTION OF GUEST SPEAKER—Mrs. Perry M. White, Atlanta, *Third Vice-President and Councilor to Southern Medical Auxiliary*

ADDRESS—Mrs. Erle E. Wilkinson, Nashville, Tenn., *President, Woman's Auxiliary to the Southern Medical Association*

Business Session

(All Reports limited to two minutes)

CONVENTION RULES OF ORDER—Mrs. George W. Statham, Atlanta, *Parliamentarian and Past President*

ROLL CALL AND MINUTES—Mrs. Milton F. Bryant, Jr., Atlanta, *Recording Secretary*

TREASURER'S REPORT (Including Auditor's Report)—Mrs. George Harrison, Marietta, *Treasurer*

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA—F. G. Eldridge, M.D., Valdosta, *Chairman*

PRESIDENT'S REPORT—Mrs. Cliff Moore, Jr., Rome

PRESIDENT-ELECT'S REPORT—Mrs. John G. Bates, Cuthbert

ADDENDUM REPORTS—State Officers and Chairmen—(Complete reports are published in the 1972-73 annual report book)

RECOMMENDATIONS FROM EXECUTIVE BOARD—Mrs. Milton F. Bryant, Jr., Atlanta

REPORT OF REVISION COMMITTEE—Mrs. S. William Clark, Jr., Waycross, *Chairman*

REPORT OF THE BUDGET AND FINANCE COMMITTEE—Mrs. James C. Roper, Jasper, *Chairman*

REPORT OF THE RESOLUTIONS COMMITTEE—Mrs. Fred O. Kessler, Jr., Savannah, *Chairman and First District Councilor*

ANNOUNCEMENTS

12:00 Recess of Session

12:00 Abner W. Calhoun Lectureship to "Before the First Shot . . ."

1:00 *Embassy Room, Richmond Motor Hotel*
James W. Turpin, M.D., *Founder and International Director of Project Concern*

1:00 Reception and Awards Luncheon

Old Medical College Garden Center

598 Telfair Street, Augusta

(Transportation will be available)

HONORING—Mrs. Willard C. Scrivner, East St. Louis, Ill., *President-Elect, Woman's Auxiliary to the AMA*; Mrs. Erle E. Wilkinson, Nashville, Tenn., *President, Woman's Auxiliary to the Southern Medical Association*

PRESIDING—Mrs. Cliff Moore, Jr., Rome, *President*

INVOCATION—Mrs. Benjamin Bashinski, Jr., Macon, *First Vice President*

PLEDGE OF LOYALTY AND COLLECT—Mrs. Benjamin Bashinski, Jr., Macon, *First Vice President*

INTRODUCTION OF GUESTS AND COUNTY PRESIDENTS

INTRODUCTION OF GUEST SPEAKER—Mrs. John G. Bates, Cuthbert, *President-Elect*

ADDRESS—Mrs. Willard C. Scrivner, East St. Louis, Ill., *President-Elect, Woman's Auxiliary to the American Medical Association*

REPORT OF AWARDS COMMITTEES
ACHIEVEMENT AWARD—Mrs. Milton B. Satcher, Jr., Atlanta, *Chairman*

AMA-ERF AWARDS—Mrs. Russell E. Andrews, Jr., Rome, *Chairman*

HEALTH CAREERS AWARDS—Mrs. Leonard Brown, Atlanta, *Chairman*

MARIE S. BURNS SAFETY AWARD—Mrs. Luther B. Otken, Augusta, *Chairman*

MRS. JAMES BONNER WHITE SCRAPBOOK AWARDS—Mrs. James H. Smith, Rome, *Chairman*

JAMES N. BRAWNER, SR., M.D., AWARDS FOR EXCELLENCE—Mrs. George W. Statham, Atlanta, *Chairman*

(Winners of Awards will please remain in Garden Center after adjournment for official photographs)

ADJOURNMENT

2:00 MAG General Meeting "Is There a Crisis in American Medicine?"

Embassy Room

Richmond Motor Hotel

6:30 Alumni Receptions and Dinners
to (See MAG Program)
9:00

SATURDAY, MAY 12

8:00 Past Presidents' Breakfast (Dutch)
Kings Inn Balcony
Richmond Motor Hotel

PRESIDING—Mrs. George W. Statham,
Atlanta, *Past President*

9:00 Registration and Information
to *Richmond Hall*
5:00 *Richmond Motor Hotel*

9:00 Art Show
to *Second Floor Motor Lobby*
5:00 *Richmond Motor Hotel*

9:00 Hospitality
to **Show and Tell Exhibits**
5:00 *Second Floor Motor Lobby*
Richmond Motor Hotel

11:00 Reception and Luncheon Meeting
to *Georgian Room*
3:00 *Richmond Motor Hotel*

HONORING—Mrs. John G. Bates, Cuthbert, and state chairmen

PRESIDING—Mrs. Cliff Moore, Jr.,
Rome, *President*

INVOCATION—"A Physician's Wife's Prayer" composed by Rev. Harvey A. Hartman—Mrs. Terrell L. Davis, Tifton, *President, Tift County Medical Auxiliary*

INTRODUCTION OF PAST PRESIDENTS AND GUESTS—Mrs. John A. Meier, Albany, *Past President*

REPORT FROM SOUTHERN MEDICAL AUXILIARY—Mrs. Perry M. White, Atlanta, *Councilor to Southern Medical Association*

REPORT OF NOMINATING COMMITTEE—Mrs. George W. Statham, Atlanta, *Chairman*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—Mrs. Willard C. Scrivner, East St. Louis, Ill., *President-Elect, Woman's Auxiliary to the American Medical Association*

INAUGURAL ADDRESS AND ANNOUNCEMENTS OF 1973-74 STATE CHAIRMEN—Mrs. John G. Bates, Cuthbert, *President*

PRESENTATION OF PAST PRESIDENT'S PIN—Mrs. George W. Statham, Atlanta, *Past President*

INTRODUCTION OF GUEST SPEAKER—Mrs. Hayward S. Phillips, Augusta, *Past President*

GUEST SPEAKER—Mrs. Fred A. Ware (Runa Erwin Ware), Augusta, Author of *All Those in Favor Say Something*
REPORT OF CREDENTIALS COMMITTEE—Mrs. Harry B. O'Rear, Augusta, *Chairman*

ANNOUNCEMENTS

ADJOURNMENT

3:30 Post-Convention Executive Board
to **Meeting and School of Instruction**
4:30 *Georgian Room*
Richmond Motor Hotel

PRESIDING—Mrs. John G. Bates, Cuthbert, *President*

2:00 MAG General Meeting "Medical-
to **Legal Problems"**
5:00 *Embassy Room*
Richmond Motor Hotel

6:30 Richmond County Medical Society
Social Hour
(All MAG Members, Their Wives, and Exhibitors Invited)
Pool Terrace/Georgian Room
Richmond Motor Hotel

8:00 Annual Banquet
Embassy Room
Richmond Motor Hotel

SUNDAY, MAY 13

7:30 MAG Medicine and Religion Breakfast
Georgian Room
Richmond Motor Hotel

9:00 MAG General (Final) Session
Embassy Room
Richmond Motor Hotel

(All MAG and Auxiliary Members and Guests Invited)

MEMORIAL SERVICE FOR MAG AND WAMAG—Rabbi Norman M. Goldberg, Augusta
Embassy Room
Richmond Motor Hotel

PRESENTATION OF AWARDS

ELECTION AND INSTALLATION OF OFFICERS

ADJOURNMENT

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA 1972-1973

Officers

<i>President</i>	MRS. CLIFF MOORE, JR. 115 Saddle Mountain Road, Rome, Georgia 30161
<i>President-Elect</i>	MRS. JOHN G. BATES 515 Court Street, Cuthbert, Georgia 31740
<i>First Vice-President</i>	MRS. BENJAMIN BASHINSKI, JR. 445 Lamar Drive, Macon, Georgia 31204
<i>Second Vice-President</i>	MRS. JOHN L. HOBSON 4003 Riverside Drive, Brunswick, Georgia 31520
<i>Third Vice-President</i>	MRS. PERRY M. WHITE 1547 Cave Road, N.W., Atlanta, Georgia 30327
<i>Area Vice-Presidents</i>	
<i>North Georgia</i>	MRS. PHIL C. ASTIN, JR. 100 Remington Circle, Carrollton, Georgia 30117
<i>Middle Georgia</i>	MRS. HARRY B. O'REAR 3069 Hillsdale Drive, Augusta, Georgia 30904
<i>South Georgia</i>	MRS. W. JACK SMITH Riverside Drive, Brunswick, Georgia 31520
<i>Recording Secretary</i>	MRS. MILTON F. BRYANT 3569 Dumbarton Road, N.W., Atlanta, Georgia 30327
<i>Corresponding Secretary</i>	MRS. JACK MARION WALDREP 201 Greenview Road, Rome, Georgia 30161
<i>Treasurer</i>	MRS. GEORGE HARRISON 576 Pickett Road, S.W., Marietta, Georgia 30060
<i>Historian</i>	MRS. ROBERT M. FINE 2025 Breckenridge Drive, N.E., Atlanta, Georgia 30345
<i>Parliamentarian</i>	MRS. GEORGE W. STATHAM The Paces, 148 Bocage Walk, N.W., Atlanta, Georgia 30305

1972-73 State Committee Chairmen Auxiliary Activities Division

<i>AMA-ERF</i>	MRS. RUSSELL ANDREWS, JR. Route 8, Kingston Road, Rome, Georgia 30161
<i>AMA-ERF (Co-chairman)</i>	MRS. ROY W. VANDIVER 4079 Indian Lake Circle, Stone Mountain, Georgia 30083
<i>Health Careers</i>	MRS. LEONARD BROWN 1050 Mountain Creek Trail, N.W., Atlanta, Georgia 30328
<i>GaMPAC</i>	MRS. J. DANIEL BATEMAN 2105 Beattie Road, Albany, Georgia 31701
<i>Legislation</i>	MRS. PERRY M. WHITE 1547 Cave Road, N.W., Atlanta, Georgia 30327
<i>International Health</i>	MRS. FRED O. KESSLER, JR. 526 E. 53rd Street, Savannah, Georgia 31405

Community Health Education (Programs)

<i>Health Education and Resource</i>	MRS. WILLIAM J. BRANAN, JR. 2592 River Oak Drive, Decatur, Georgia 30033
<i>Health Education and Resource (Co-chairman)</i>	MRS. WILLIAM J. PENDERGRAST 3398 Briarcliff Road, N.E., Atlanta, Georgia 30345
<i>Community Health</i>	MRS. GARLAND P. BENNETT, JR. 2053 Starfire Drive, N.E., Atlanta, Georgia 30345
<i>Nutrition</i>	MRS. CHARLES M. WARD P.O. Box 203, Dawson, Georgia 31742
<i>Aging and Homebound</i>	MRS. JOHN M. ANDERSON 3844 Club Drive, N.E., Atlanta, Georgia 30319
<i>Children and Youth</i>	MRS. THOMAS E. FULGHUM 510 Valley Drive, Dalton, Georgia 30720
<i>Mental Health</i>	MRS. CHARLES G. BURTON 911 Dogwood Circle, Macon, Georgia 31204
<i>Rural Health</i>	MRS. EMORY W. HOLLOWAY, JR. 180 Parkview Drive, Commerce, Georgia 30529

Health Services (Projects)

<i>Hospital Day Care Centers</i>	MRS. NORMAN B. PURSLEY 3427 Old Savannah Road, Augusta, Georgia 30906
<i>Safety-Disaster Preparedness</i>	MRS. LUTHER B. OTKEN 3277 Hillwood Lane, Augusta, Georgia 30904
<i>Environmental Health</i>	MRS. JAMES H. SULLIVAN 2519 Craigston Drive, Columbus, Georgia 31906
<i>Blood Donor</i>	MRS. EARL T. MCGHEE 808 Atkinson Drive, Dalton, Georgia 30720

Editorial (Pulse Line) and Public Relations

<i>Editor Pulse Line</i>	MRS. HENRY D. MEADERS 244 Seminole Drive, N.E., Marietta, Georgia 30060
<i>Circulation</i>	MRS. CHARLES J. REY, JR. 3514 Cochise Drive, N.W., Atlanta, Georgia 30339

Awards Committees

<i>Achievement Awards</i>	MRS. MILTON B. SATCHER, JR. 1171 West Paces Ferry Road, N.W., Atlanta, Georgia 30327
<i>AMA-ERF</i>	MRS. RUSSELL ANDREWS, JR. Route 8, Kingston Road, Rome, Georgia 30161

James N. Brawner, Sr., M.D. Certificate of Excellence

<i>Scrapbook</i>	MRS. GEORGE W. STATHAM The Paces, 148 Bocage Walk, N.W., Atlanta, Georgia 30305
<i>Scrapbook (Judges' Chairman)</i>	MRS. CARL S. PITTMAN, JR. 415 W. 18th Street, Tifton, Georgia 31794
<i>Marie S. Burns Safety Award</i>	MRS. JAMES SMITH 216 East 9th Street, Rome, Georgia 30161
<i>Health Careers Awards</i>	MRS. LUTHER B. OTKEN 3277 Hillwood Lane, Augusta, Georgia 30904
	MRS. LEONARD BROWN 1050 Mountain Creek Trail, N.W., Atlanta, Georgia 30328

Internal Affairs Committees

<i>Archives</i>	MRS. ROY G. DUNCAN 509 Heyward Circle, N.W., Marietta, Georgia 30060
<i>Budget and Finance</i>	MRS. C. JAMES ROPER 992 South Main Street, Jasper, Georgia 30143
<i>Bylaws and Revisions</i>	MRS. S. WILLIAM CLARK, JR. 1409 Satilla Boulevard, Waycross, Georgia 31501
<i>Convention</i>	MRS. STEPHEN MULHERIN 2233 Kings Way, Augusta, Georgia 30904
<i>Crawford W. Long Stationery</i>	MRS. FRANK BLALOCK 100 Branham Avenue, Apt. 1, Rome, Georgia 30161
<i>Doctor's Day</i>	MRS. PAUL T. SCOGGINS 222 Washington Avenue, Commerce, Georgia 30529
<i>Membership</i>	MRS. BENJAMIN BASHINSKI, JR. 445 Lamar Drive, Macon, Georgia 31204
<i>Philanthropy</i>	MRS. JAMES HUNT MANNING 643 Kennesaw Avenue, N.W., Marietta, Georgia 30060
<i>Philanthropy (Co-chairman)</i>	MRS. HAYWARD S. PHILLIPS 1082 Bertram Road, Augusta, Georgia 30904
<i>Philanthropy (Co-chairman)</i>	MRS. LOUIE H. GRIFFIN P.O. Box 547, Claxton, Georgia 30417
<i>Program</i>	MRS. JOHN L. HOBSON 4003 Riverside Drive, Brunswick, Georgia 31520
<i>Program Development</i>	MRS. JOHN G. BATES 515 Court Street, Cuthbert, Georgia 31740
<i>Research and Romance of Medicine</i>	(no chairman)
<i>William R. Dancy, M.D., Student Loan Fund</i>	MRS. WILLIAM N. AGOSTAS 2302 Overton Road, Augusta, Georgia 30904
<i>William R. Dancy, M.D., Student Loan Fund (Co-chairman)</i>	MRS. HARRY B. O'REAR 3069 Hillsdale Drive, Augusta, Georgia 30904
<i>William R. Dancy, M.D., Student Loan Fund (Co-chairman)</i>	MRS. RONALD F. GALLOWAY 818 Windsor Court, Augusta, Georgia 30904
<i>WA-SAMA Liaison</i>	MRS. HOWARD S. BROWN 5621 Ball Mill Road, Dunwoody, Georgia 30338

Councilor to Woman's Auxiliary to Southern Medical Association

MRS. PERRY M. WHITE
1547 Cave Road, N.W., Atlanta, Georgia 30327

District Councilors

<i>First District</i>	MRS. FRED O. KESSLER, JR. 526 E. 53rd Street, Savannah, Georgia 31405
<i>Second District</i>	MRS. T. GRAY FOUNTAIN 4001 Old Dawson Road, Albany, Georgia 31701
<i>Third District</i>	MRS. CLAYTON TAYLOR 2710 Auburn Avenue, Columbus, Georgia 31906
<i>Sixth District</i>	MRS. JOE SAM ROBINSON 740 Pierce Avenue, Macon, Georgia 31204
<i>Seventh District</i>	MRS. J. RUEL MCMILLIAN 3 Beaver Run, Rome, Georgia 30161
<i>Eighth District</i>	MRS. JOSEPH RAYMOND MARTINEZ 701 City Boulevard, Waycross, Georgia 31501
<i>Ninth District</i>	MRS. PAUL T. SCOGGINS 222 Washington Avenue, Commerce, Georgia 30529
<i>Tenth District</i>	MRS. ROBERT SPEARS 809 Kamel Circle, Augusta, Georgia 30904

Advisory Committee From the Medical Association of Georgia

<i>Braswell E. Collins, M.D., Chairman</i>	800 First Street Macon, Georgia 31204
<i>W. C. Mitchell, M.D.</i>	Mitchell Building Smyrna, Georgia 30080
<i>F. W. Dowda, M.D.</i>	490 Peachtree Street, N.E. Atlanta, Georgia 30308
<i>Milton I. Johnson, M.D., AMA-ERF Liaison</i>	2605 Cherokee Avenue Macon, Georgia 31204
<i>George W. Statham, M.D.</i>	341 West Ponce de Leon Avenue Decatur, Georgia 30030
<i>S. W. Clark, Jr., M.D.</i>	P.O. Box 951 Waycross, Georgia 31501

Cliff Moore, Jr., M.D. 304 East Second Street
Rome, Georgia 30161
John G. Bates, M.D. 201 Randolph Street
Cuthbert, Georgia 31740
W. G. Elliott 201 Randolph Street
Cuthbert, Georgia 31740

The Medical Association of Georgia Related Committees

Cancer Hoke Wammock, M.D., Chairman
Enoch Callaway Cancer Clinic, LaGrange, Georgia 30240
Communications Robert P. Wight, Chairman
P.O. Box 1186, Tifton, Georgia 31794
Ecology John Kirk Train, M.D., Chairman
1107 Bull Street, Savannah, Georgia 31401
Education John Rhodes Haverty, M.D., Chairman
33 Gilmer Street, S.E., Atlanta, Georgia 30303
Subcommittee on Allied Health John T. Godwin, M.D., Chairman
265 Ivy Street, N.E., Atlanta, Georgia 30308
Historical Milford B. Hatcher, M.D., Chairman
781 Spring Street, Macon, Georgia 31201
Legislation J. Frank Walker, M.D., Chairman (National)
1293 Peachtree Street, N.E., Atlanta, Georgia 30309
Harrison L. Rogers, M.D., Chairman (State)
1293 Peachtree Street, N.E., Atlanta, Georgia 30309
Maternal and Infant Welfare Eugene L. Griffin, M.D., Chairman
490 Peachtree Street, N.E., Atlanta, Georgia 30308
Mental Health A. S. Yochem, M.D., Chairman
1970 Cliff Valley Way, N.E., Atlanta, Georgia 30329
Rural Health Irving D. Hellenga, M.D., Chairman
Toccoa, Georgia 30577
School Child Health Fred L. Allman, M.D., Chairman
33 North Avenue, N.E., Atlanta, Georgia 30308

Past Presidents and Conventions

Honorary President for Life
Mrs. Eustace A. Allen, Atlanta
Mrs. Ralph H. Chaney, Augusta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta
(Deceased), Temporary Chairman
1925—Atlanta—Mrs. James N. Bawner, Sr., Atlanta (Deceased)
1926—Albany—Mrs. William H. Myers, Savannah
1927—Athens—Mrs. C. W. Roberts, Atlanta (Deceased)
1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney,
S.C.)
1929—Macon—Mrs. Charles C. Hinton, Macon
1930—Augusta—Mrs. Marion T. Benson, Atlanta (Deceased)
1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased)
1932—Savannah—Mrs. Ralston Lattimore, Savannah
1933—Macon—Mrs. S. T. R. Revell, Louisville
1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
1935—Atlanta—Mrs. J. E. Penland, Waycross
1936—Savannah—Mrs. Ernest R. Harris, Winder (Deceased)
1937—Macon—Mrs. William R. Dancy, Savannah
1938—Augusta—Mrs. Ralph H. Chaney, Augusta
1939—Atlanta—Mrs. Warren A. Coleman, Eastman
1940—Savannah—Mrs. Eustace A. Allen, Atlanta
1941—Macon—Mrs. H. G. Bannister, Ila
1942—Augusta—Mrs. Lee Howard, Savannah
1943—Atlanta—Mrs. J. Lon King, Macon (Deceased)
1944—Savannah—Mrs. Olin S. Cofer, Atlanta
1945—No Convention
1946—Macon—Mrs. W. T. Randolph, Winder
1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
1949—Savannah—Mrs. S. A. Anderson, Atlanta
1950—Macon—Mrs. J. Harry Rogers, Atlanta
1951—Augusta—Mrs. Lehman W. Williams, Savannah
1952—Atlanta—Mrs. J. R. S. Mays, Macon
1953—Savannah—Mrs. Ralph W. Fowler, Marietta (Deceased)
1954—Macon—Mrs. Leo Smith, Waycross
1955—Augusta—Mrs. Shelley C. Davis, Atlanta
1956—Atlanta—Mrs. Robert C. Major, Augusta
1957—Savannah—Mrs. Walker L. Curtis, College Park
1958—Macon—Mrs. John L. Elliott, Savannah
1959—Augusta—Mrs. Luther H. Wolff, Columbus
1960—Columbus—Mrs. Remer Y. Clark, Marietta
1961—Atlanta—Mrs. W. P. Rhyne, Albany
1962—Savannah—Mrs. A. Worth Hobby, Atlanta
1963—Jekyll Island—Mrs. E. W. Waldemayer, Americus
1964—Macon—Mrs. John E. Porter, Savannah
1965—Augusta—Mrs. John T. Leslie, Avondale Estates
1966—Columbus—Mrs. Louie H. Griffin, Sr., Claxton
1967—Atlanta—Mrs. John Meier, Albany
1968—Augusta—Mrs. James H. Manning, Marietta
1969—Savannah—Mrs. Hayward S. Phillips, Augusta
1970—Jekyll Island—Mrs. S. Wm. Clark, Jr., Waycross
1971—Atlanta—Mrs. Charles R. Smith, Columbus
1972—Macon—Mrs. George W. Statham, Atlanta

County Presidents and Presidents-Elect 1972-1973

Baldwin President, Mrs. Pedro Tamayo
165 Annex Drive, Milledgeville, Georgia 31061
President-Elect, Mrs. Wilbur E. Baugh
P.O. Box 926, Milledgeville, Georgia 31061
Bibb President, Mrs. Robert S. McMichael
753 Fair Oaks Drive, Macon, Georgia 31204
President-Elect, Mrs. Jack F. Menendez
1855 Lincoln Road, Macon, Georgia 31204

Carroll-Douglas-Haralson President, Mrs. Walter S. Gresham
P.O. Box 520, Bowdon, Georgia 30108
President-Elect, Mrs. Allen Batchelor
125 Windmore Drive, Bremen, Georgia 30110
Cherokee-Pickens President, Mrs. L. A. Flint
Butterworth Road, Canton, Georgia 30114
President-Elect—(None)
Cobb President, Mrs. Prentiss E. Parker
134 McDonald Street, S.W., Marietta, Georgia 30060
President-Elect, Mrs. William T. Layne
865 Hickory Drive, S.W., Marietta, Georgia 30060
Coffee President, Mrs. Diskin G. Morgan
North Gaskin Avenue, Douglas, Georgia 31533
President-Elect, Mrs. John Herndon
Touchton Woods, Douglas, Georgia 31533
Crawford W. Long President, Mrs. Larry Cohen
190 Broomsedge Trail, Athens, Georgia 30601
President-Elect, Mrs. Joseph Caskin
185 Spruce Valley Road, Athens, Georgia 30601
Decatur-Seminole President, Mrs. Jacob H. Holley
302 N. Wiley Avenue, Donalsonville, Georgia 31745
President-Elect, Mrs. Wilton B. Reynolds
Route 3, Box 69E, Donalsonville, Georgia 31745
DeKalb President, Mrs. B. Donald Minor
2256 Sagamore Hills Drive, Decatur, Georgia 30033
President-Elect, Mrs. Ralph Tillman
Route 3, Lester Road, Lawrenceville, Georgia 30245
Dougherty President, Mrs. Joseph L. Berg
1603 Lynwood Lane, Albany, Georgia 31705
President-Elect, Mrs. D. Morton Boyette
2605 Northgate Road, Albany, Georgia 31705
Elbert-Franklin-Hart President, Mrs. Stewart Dixon Brown, Jr.
569 Franklin Square, Royston, Georgia 30662
President-Elect—(None)
Flint President, Mrs. Perry G. Busbee
714 23rd Avenue E., Cordele, Georgia 31015
President-Elect—(None)
Floyd-Polk-Chattooga President, Mrs. Russell E. Andrews, Jr.
Route 8, Kingston Road, Rome, Georgia 30161
President-Elect, Mrs. J. Ruel McMillan
3 Beaver Run, Rome, Georgia 30161
Georgia Medical President, Mrs. H. Rodney Hartmann
102 McIntosh Drive, Savannah, Georgia 31406
President-Elect, Mrs. Frank E. Carlton
2608 Atlantic Circle, Savannah, Georgia 31405
Glynn President, Mrs. Michael A. Glucksman
152 Fairway Oaks Drive, Brunswick, Georgia 31520
President-Elect, Mrs. M. F. Engel
728 Oglethorpe Avenue, St. Simons Island, Georgia 31522
Gordon President, Mrs. Robert D. Walter
334 South Wall Street, Calhoun, Georgia 30701
President-Elect, Mrs. William Thompson
Route 1, Calhoun, Georgia 30701
Hall President, Mrs. J. R. Wright
776 Holly Drive, N.W., Gainesville, Georgia 30501
President-Elect, Mrs. James Burns
789 Sherwood Road, N.W., Gainesville, Georgia 30501
Jackson-Banks President, Mrs. Joe Griffith
Jefferson Road, Commerce, Georgia 30529
President-Elect—(None)
Laurens President, Mrs. Ridley M. Glover
415 Woods Avenue, P.O. Box 644, Dublin, Georgia 31021
President-Elect, Mrs. James A. Kibler
1803 Pine Circle, Dublin, Georgia 31021
Medical Association of Atlanta President, Mrs. J. Hagan Baskin
2283 Sagamore Hills Drive, Decatur, Georgia 30033
President-Elect, Mrs. George M. Callaway, Jr.
1170 Oakdale Road, N.E., Atlanta, Georgia 30307
Muscogee President, Mrs. Julian Sizemore
2507 Lynda Lane, Columbus, Georgia 31906
President-Elect, Mrs. Edmund J. Molnar
2964 Roswell Lane, Columbus, Georgia 31906
Ogeechee River President, Mrs. William F. Kent
102 Benson Drive, Statesboro, Georgia 30458
President-Elect—(None)
Peach Belt President, Mrs. Ronald G. Severs
100 Beverly Road, Bonaire, Georgia 31005
President-Elect—(None)
Randolph-Stewart-Terrell President, Mrs. Charles Ward
P.O. Box 203, Dawson, Georgia 31742
President-Elect—(None)
Richmond President, Mrs. Daniel H. G. Glover
2100 McDowell Street, Augusta, Georgia 30904
President-Elect, Mrs. George Musket
601 Gary Street, Augusta, Georgia 30904
South Georgia President, Mrs. Fred Smith
906 Millpond Road, Valdosta, Georgia 31601
President-Elect, Mrs. Quentin Lawson
2409 Meadowbrook Drive, Valdosta, Georgia 31601
Southeast Georgia President, Mrs. George W. Merritt
506 Cheney Drive, Vidalia, Georgia 30474
President-Elect—(None)
Stephens President, Mrs. J. Wade Knowlton
138 Woodlane Drive, Toccoa, Georgia 30577
President-Elect—(None)
Sumter President, Mrs. James G. Herron
411 Peggy Ann Drive, Americus, Georgia 31709
President-Elect, Mrs. H. A. Keuls
Eckles Road, Americus, Georgia 31709
Thomas-Brooks-Grady President, Mrs. Randolph Malone
143 Tuxedo Drive, Thomasville, Georgia 31792
President-Elect, Mrs. James R. Neill
110 Imperial Drive, Thomasville, Georgia 31792
Tift President, Mrs. Terrell L. Davis
710 Marty Lane, Tifton, Georgia 31794
President-Elect, Mrs. Robert P. Wright
1421 Maryanne Avenue, Tifton, Georgia 31794
Troup President, Mrs. Earle Lewis
233 Westwood Drive, LaGrange, Georgia 30240
Upson President, Mrs. Douglas L. Head, Jr.
P.O. Box 591, Thomaston, Georgia 30286
President-Elect—(None)

Walker-Catoosa-Dade President, Mrs. Richard K. Cureton
3517 Rhoda Lane, Murray Hills, Chattanooga, Tennessee 37416
President-Elect, Mrs. John Ellis
75 South Crest Road, Chattanooga, Tennessee 37404
Ware President, Mrs. Michael Joseph O'Connell
1108 Coral Road, Waycross, Georgia 31501
President-Elect, Mrs. Robert C. Smith
P.O. Box 804, Waycross, Georgia 31501

Whitfield-Murray President, Mrs. James Oosterhoudt
1044 Lakeshore Drive, Dalton, Georgia 30720
President-Elect, Mrs. Fort Felker
1604 Rio Vista Drive, Dalton, Georgia 30720
Worth President, Mrs. Robert T. Morgan
Greenbriar Avenue, Sylvester, Georgia 31791
President-Elect, Mrs. J. L. Tracey, Jr.
508 North Main, Sylvester, Georgia 31791

CONVENTION COMMITTEE

General Chairman

Mrs. C. Stephen Mulherin, Augusta

Registration and Credentials

Mrs. Harry B. O'Rear, Augusta

Tellers

Mrs. Jack F. Menendez, Macon
Mrs. Louie H. Griffin, Sr., Claxton

Timekeepers

Mrs. Ralph H. Chaney, Augusta
Mrs. Joseph L. Berg, Augusta

Reading Committee

Mrs. Donald Minor, Decatur
Mrs. George M. Callaway, Jr., Atlanta
Mrs. D. Morton Boyette, Albany

Courtesy Committee

Mrs. Robert Horseman, Augusta
Mrs. Robert Mushet, Augusta

Art Committee

Mrs. William A. Fuller, Augusta

Hospitality Committee

Mrs. James Becton, Augusta

Pages

Mrs. Harold Engler, Augusta

Finance

Mrs. Mark Brown, Augusta

Publicity

Mrs. Ronald F. Galloway, Augusta

Friday Luncheon

Mrs. Henry D. Scoggins, Augusta
Mrs. Norman B. Pursley, Gracewood

Resolutions Committee

Mrs. Fred O. Kessler, Jr., Savannah
Mrs. Jack M. Waldrep, Rome

Saturday Luncheon

Mrs. Luther Otken, Augusta
Mrs. E. K. McLain, Augusta

Past Presidents' Breakfast

Mrs. Hayward N. Phillips, Augusta

Flowers for President's Banquet

Mrs. William N. Agostas, Augusta

Transportation

Mrs. Robert Piper, Augusta

Displays

Mrs. G. Pat Williams, Augusta
Mrs. Alex Robertson, Augusta

Information

Mrs. Curtis Carter, Augusta

Secretary

Mrs. Robert Spears, Augusta

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

Medical Association of Georgia

Annual Session

MAY 10-13, 1973—Augusta, Georgia

RESERVATION REQUEST

1. Please complete this form and mail to: Reservation Department
(Motel or hotel of your choice)
Augusta, Georgia (Proper Zip Code)
2. Special reservation forms will be mailed to officers, councilors, delegates and special out-of-state guest speakers for rooms at the Richmond Hotel (headquarters hotel).
3. Assignment of rooms will be made in order of receipt of reservation. If possible, confirmation will be in accordance with preference indicated; if not, best substitute will be made.
4. Unreserved accommodations will be released on April 30, 1973.
5. Rooms will not be ready for occupancy until 2:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.

DAILY MOTEL/HOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

NAME OF MOTEL	Bedroom, 1-2 Persons	Each Additional Person
Holiday Inn of Augusta	Single—\$12.00-14.00	\$2.00
1602 Fort Gordon Highway, Augusta, Ga. 30906	Double—\$15.00-17.00	
Horne's Motor Lodge	Single—\$11.00-15.00	2.00
1520 Gordon Highway, Augusta, Ga. 30906	Double—\$15.00-17.00	
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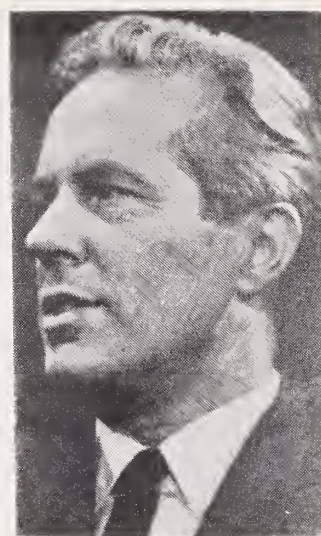
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SYMPOSIUM '73—"THE CREATION OF MAN"

To explore the many areas of man's creation, to examine the factors shaping the course of his evolution to the present with some speculation on his future development is the aim of Symposium '73.

Following the theme "The Creation of Man," the Cobb County Medical Society has worked with the Cobb Bar Association, Cobb Ministerial Association and Kennesaw Junior College to prepare the eighth annual symposium, scheduled this year on April 27-28 at the junior college.

Opening speaker Friday is Dr. George K. Schweitzer, University of Tennessee, setting the mood with an address, "The Creation of the Universe and Man." He will be followed by speakers in the fields of religion and law: Rabbi Alvin J. Reines of the Jewish Seminary in Cincinnati on "The Early Religious Development of Western Man"; and a lawyer on "The Origin, Growth and Development of Western Law and Its Influence on Evolving Man."

Friday evening's banquet and address will be held at Stouffer's Atlanta Inn. Dr. Harold Taylor, philosopher-

educator, will speak on "Creative and Cultural Forces Shaping Present and Modern Man." Dr. Taylor was formerly president of Sarah Lawrence College and is now a prolific writer in the fields of education, the arts and social change.

Returning to Kennesaw Junior College Saturday morning, the opening address will be made by Dr. Cynthia Epstein of Columbia University, author of *A Woman's Place*. Her topic is entitled, "A Woman's Place: A View of Women's Liberation 1973."

Other speakers that morning include Dr. Howard Higman, chairman of the Department of Sociology of the University of Colorado, speaking on "Some Sociological Aspects of Evolving Man—The Genetic Society"; and Dr. Paul Ramsey of Princeton University, "Ethical Issues in Genetic and Reproductive Engineering."

Additional information and application forms are available by writing Symposium '73, Kennesaw Junior College, Marietta, Georgia 30060.



Dr. Cynthia Epstein



Prof. Howard Higman



Dr. Paul Ramsey

These tumors of the gastrointestinal tract are unusual in that the primary lesion is asymptomatic unless it causes obstruction, while its metastases outside the area drained by the hepatic portal vein may produce a definite constellation of symptoms—the carcinoid syndrome.

Carcinoid Tumor of Meckel's Diverticulum: Report of a Case and Review of Literature

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HARVEY KRIEGER, M.D., F.A.C.S., KURT E. GERSTMANN, M.D. and
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CARCINOID TUMORS arise from specific cells of the mucosa of the alimentary tract and are more frequent in the appendix than in other parts of the tract (Figure 1). They were recognized late in the last century and given the name "carcinoid" in 1907 by Oberndorfer³⁷ who also described the first such tumor in Meckel's diverticulum. The carcinoid syndrome was recognized by Thorson and his colleagues in 1954.⁵⁶

Although Meckel's diverticulum is present in only about two per cent of individuals, more carcinoid tumors arise from this structure than might be expected. By 1969, there were 40 cases in the literature.⁵⁸ The case presented here is the 50th case of carcinoid tumor of Meckel's diverticulum. (Table 1)

Case Report

A 60-year-old white male was admitted to the hospital on April 10, 1968 with the chief complaint of progressively increasing, steady pain of three days duration in the paraumbilical region. The pain later shifted to the right lower quadrant. The patient denied previous history of chronic diarrhea, dysuria, asthmatic attack and facial flushing. His past medical health was not remarkable.

Pertinent physical findings were marked pain and tenderness in the right lower quadrant with muscular rigidity and decreased bowel sounds. White blood cell count was 16,000 with 75 per cent segmented

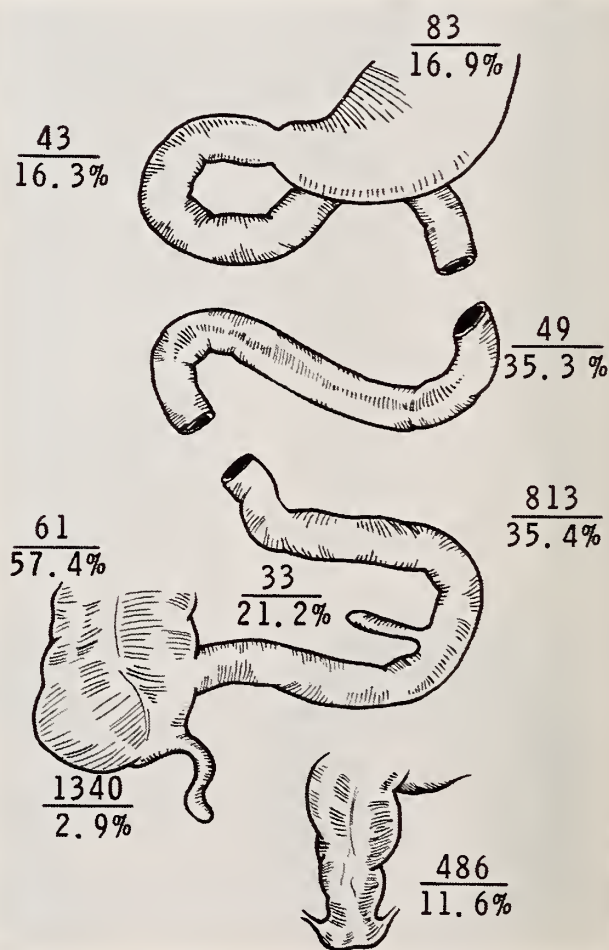


FIGURE 1

Incidence of carcinoid tumors and the percentage metastasizing in various segments of the gastrointestinal tract. Figure above the line is the number of cases reported; figure below the line is the per cent having metastasized. Figures from Postlethwait (1966).

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TABLE 1
CASE REPORTS

Author	Age	Sex	Size (mm)	Specimen	Metastases	Diverticulitis	Comment
Oberndorfer (1907)	68	M	—	Autopsy	None	—	2 pea sized tumors
Schaetz (1925)	69	M	—	Autopsy	None	—	—
Stewart and Taylor (1926)	54	M	pea	Autopsy	None	—	—
Price (1935)	54	F	15	Surgery	None	Yes	Resection of small bowel with diverticulum. Patient died 5 days later
Hertzog and Carlson (1935)	54	M	4	Autopsy	None	—	—
Hertzog and Carlson (1935)	58	M	3	Autopsy	None	—	—
Collins, et al. (1938)	56	M	6	Surgery	None	Yes	Diverticulectomy. Inflammation found at laparotomy for small bowel obstruction
Ashworth and Wallace (1941)	46	M	8	Autopsy	None	—	—
Pautler and Scotti (1951)	68	M	6	Autopsy	None	—	—
Mrazek, et al. (1953)	37	M	—	Surgery	None	—	Incidental diverticulectomy at appendectomy (normal appendix)
Mrazek, et al. (1953)	54	M	3	Autopsy	None	—	—
Stoll (1953)	58	M	5	Autopsy	Liver	—	—
(Kravetz, et al. case 2)							
Pierce (1955)	47	M	—	Surgery	None	—	Incidental diverticulectomy at operation for perforated sigmoid diverticulitis
Grimes and Crane (1955)	59	F	15	Surgery	Liver	—	Diverticulectomy at laparotomy for pain and metastatic nodules in liver. No syndrome
Snow, et al. (1955)	58	F	10	Autopsy	Liver, mesenteric lymph nodes	—	Carcinoid syndrome
Eldred (1956)	50	F	—	Surgery	Liver	—	Diverticulectomy at operation for metastatic nodules in liver. No syndrome
Parnassa, et al. (1956)	56	M	5	Surgery	None	Yes	Resection of small bowel with diverticulum for diverticulitis
(Kravetz, et al. case 3)							
Baird, et al. (1958)	42	M	4	Surgery	None	—	—
Rintala (1958)	25	M	3	Surgery	None	—	Operation for appendicitis
Becker (1960)	51	M	6	Surgery	None	—	Incidental resection of small bowel with diverticulum at operation for cholelithiasis
Drickman and Hodges (1960)	71	M	8	Autopsy	Mesenteric lymph nodes	—	—
Camp and Hays (1960)	50	M	8	Surgery	None	—	Incidental diverticulectomy at exploratory laparotomy
Lykke and de la Lande (1961)	60	F	—	Autopsy	Liver, lung, mesenteric lymph nodes	—	Carcinoid syndrome
Classen, et al. (1961)	64	M	10	Surgery	None	—	Incidental diverticulectomy at operation for cholelithiasis
Ciampa (1961)	40	F	10	Surgery	None	—	Incidental diverticulectomy at hysterectomy
Lechner and Chamblin (1962)	52	M	6	Surgery	None	—	Incidental diverticulectomy at exploratory laparotomy
Kravetz, et al. (case 1) (1962)	61	M	10	Autopsy	None	—	—
Kravetz, et al. (case 4) (1962)	55	M	5	Autopsy	Liver, vertebrae, mesenteric lymph nodes	—	—
Kinley and Penner (1962)	70	M	—	Surgery	None	Yes	Incidental diverticulectomy at operation for strangulated inguinal hernia
Southam (1963)	58	F	10	Autopsy	Liver, mesentery	—	Carcinoid syndrome
Roselli and Paulino (1964)	80	M	3	Surgery	None	—	Diverticulectomy at operation for intestinal obstruction
Herena and Schraft (1964)	55	M	15	Autopsy	None	—	—
Johnston, et al. (1965)	73	M	—	Surgery	None	—	Diverticulectomy for bleeding diverticulum
Dencker and Norberg (1965)	72	M	—	Surgery	None	—	Diverticulectomy at exploratory laparotomy for strangulation of small bowel as a result of fixation of Meckel's diverticulum to the posterior abdominal wall
Doyle and Severance (1966)	55	M	—	Surgery	None	—	Incidental diverticulectomy at operation for gastric ulcer

TABLE 1 (Continued)

Author	Age	Sex	Size (mm)	Specimen	Metastases	Diverticulitis	Comment
Figuerola and Tedeschi (1967)	61	F	9	Autopsy	None	—	—
Schlicke and Johnston (1968)	76	M	10	Surgery	None	—	Incidental diverticulectomy at operation for cholecystitis
Traill (1968)	61	M	7, 2	Autopsy	None	—	2 carcinoids
Weitzner (1969)	68	M	6	Autopsy	None	—	—
Derot, et al. (1969)	60	M	15	Surgery	Liver, lymph nodes	—	Carcinoid syndrome
Abramowitz and Gien (1969)	30	M	—	Surgery	None	Yes	Diverticulectomy for inflammation
Shaw (1969)	70	M	—	Surgery	None	—	Diverticulectomy for bleeding
Letac, et al. (1969)	68	M	20	Autopsy	Liver	—	Meckel's diverticulum
Ayulo (1969)	72	F	—	Surgery	None	—	Carcinoid syndrome
Baeza (1969)	—	F	—	Surgery	None	—	Operation for bleeding colonic polyp
Kuiper, et al. (1970)	64	—	—	Surgery	None	—	Discovered during gynecologic procedure
Sax, et al. (1970)	—	M	<10	Surgery	None	—	Found at right colectomy for carcinoma of the colon
Sax, et al. (1970)	—	M	<10	Surgery	None	—	Diverticulectomy, asymptomatic
Dayan, et al. (1971)	77	M	—	Surgery	Liver	—	—
Present case (1972)	60	M	5	Surgery	None	Yes	Carcinoid syndrome
							Small bowel resection with diverticulum

forms and five per cent band cells. All liver profiles were within normal limits. A tentative diagnosis of acute appendicitis was made and a laparotomy was performed.

At operation a Meckel's diverticulum measuring 4×3 cm. was found on the antimesenteric border of the ileum about 40 cm. from the ileocecal valve. The diverticulum was inflamed, with thickening of the serosa at the tip. The appendix was normal. Nine cm. of small bowel with the diverticulum was resected and end-to-end anastomosis of the ileum was done. On opening the diverticulum, a yellowish nodule was found measuring 0.5×0.5 cm. containing groups of carcinoid cells in the submucosa and muscularis layers. There was ulceration of the overlying mucosa.

The patient's postoperative recovery was uneventful. The urinary excretion of 5-hydroxyindole-acetic acid after surgery was within normal limits. He had no signs or symptoms of the carcinoid syndrome. The postoperative liver scan, using I-labelled rose bengal, showed no evidence of hepatomegaly or secondary tumor.

The pathological report showed the specimen consists of a resected segment of small intestine with an attached diverticulum. The midportion of the diverticulum contains a yellowish, intramural nodule 0.5×0.5 cm. Sections of the diverticulum show typical ileal columnar epithelium on villous projection. The muscle layer appears thinned and the submucosa is filled with lymphocytes and neutrophils. A section through the yellowish nodule shows numerous large nodular masses of carcinoid cells in the submucosa

and muscularis with ulceration of the overlying mucosa.

Diagnosis: Carcinoid tumor of Meckel's diverticulum.

Incidence of Tumors

Carcinoid tumors of Meckel's diverticulum are rare, but the diverticulum itself is present in only two per cent of the population. Where a diverticulum is present it is affected almost as frequently as is the ileum from which it arises.

Table 2 shows a comparison of the number of tumors reported from several locations. It will be seen that per inch many more tumors occur in both appendix and Meckel's diverticulum than in the duodenum and small intestine. Diffenbaugh and Anderson¹⁷ suggested that tumors of the appendix produce

TABLE 2
RELATIVE FREQUENCY OF CARCINOID
TUMORS REPORTED IN THE
INTESTINAL TRACT

Organs	Length (inches)	No. of Tumors*	Tumors per Inch of Length
Duodenum	10	43	4.3
Jejunum	96	49	0.5
Ileum	144	813	5.6
Meckel's			
Diverticulum ..	2	33 (1650)†	16.5 (825.0)†
Appendix	3	1340	446.6

* Number reported up to 1966.

† The diverticulum is present in two per cent of patients, hence, $33 \times 50 = 1650$ for those patients with a diverticulum.

symptoms earlier in their development than do intestinal tumors and hence are reported more frequently. In their series, discovery of carcinoid tumors in the appendix was at an average age of 25 years while in the ileum it was 55 years. The average age of discovery of 47 such tumors in Meckel's diverticulum was 58.4 years. In this respect, diverticular tumors resemble ileal more than they do appendiceal tumors.

Carcinoid tumors are probably the most frequent neoplasms of Meckel's diverticulum. Up to 1959, we were able to find 15 cases of leiomyosarcoma;⁵¹ in the same period 19 carcinoid tumors had been reported. In the appendix, where carcinoid tumors are common, only three leiomyosarcomas have been described.

Carcinoid tumors of Meckel's diverticulum are most often found in men late in middle age (Table 3). Only ten patients have been women, and 65 per cent of patients of both sexes were between 50 and 69 years of age when their tumors were discovered. There is a similar preponderance of males among patients with leiomyosarcoma of Meckel's diverticulum.⁵¹ Although the diverticulum is present in about equal numbers of men and women, it's more subject to disease of all types in the male.²

Of the 50 cases in Table 1, 12 were operated on for symptoms of their disease, in 17 the tumor was found incidental to other surgery, and in 21 the tumor was revealed only at autopsy.

Six patients, including the one reported in this paper, had diverticulitis, and in two others, there was bleeding from the diverticulum. None of this group of tumors had metastasized or produced the carcinoid syndrome.

Metastasis

Metastases were reported in 11 patients (22 per cent). In all but one case, in which only the mesenteric lymph nodes were affected, metastasis was to the liver. In one patient the lungs, and in another the vertebrae were also involved. This rate of metastasis is slightly more than that reported by Diffenbaugh and Anderson¹⁷ and Postlethwait⁴² for similar tumors in the duodenum (16.3 per cent) but less than that in the small intestine (35.4 per cent), the ileocecal valve (84.6 per cent) or the cecum (76.1 per cent). These values are in contrast to the 2.9 per cent of metastasizing carcinoid tumors of the appendix.

There appears to be a definite relation between metastasis of carcinoid tumors of Meckel's diverticulum and sex. Metastases occurred in one-half of the affected women and in only 17.5 per cent of the affected men (Table 4). This difference is statistically significant.

There is no relation between tumor size and pa-

tient's age, or tumor size and metastasis. Carcinoid tumors are small, the largest in the series vary only 2.0 centimeters in diameter (Table 5).

Carcinoid Syndrome

In six patients having metastases, the carcinoid syndrome was present; in two patients it was reported to be absent. In the remaining three cases, two of which predate understanding of the syndrome, no mention of the syndrome was made. The carcinoid syndrome is a systemic circulatory disorder characterized, at first, by episodic flushing of the face and upper body with tachycardia, occasionally resulting in vasomotor collapse. In later stages the face becomes permanently reddened; diarrhea and peripheral edema are common. The final stage of the dis-

TABLE 3
INCIDENCE OF CARCINOID TUMORS OF MECKEL'S DIVERTICULUM BY AGE AND SEX*

Age	Male	Female
20-29	1	—
30-39	2	—
40-49	3	1
50-59	13	5
60-69	10	2
70-79	7	1
80-89	1	—
Not stated	2	1
	39	10

* In one case, sex was not stated.

TABLE 4
METASTASIS OF CARCINOID TUMORS AND SEX

Sex	Metastatic	Not Metastatic
Male	6	33
Female	5	5
	11	38

Chi² = 7.67, P<0.01

TABLE 5
THE RELATION OF TUMOR SIZE TO METASTASIS

Size in mm.	Metastatic	Not Metastatic
1- 5	2	9
6-10	3	14
11-15	2	2
16-20	1	0
Not stated	3	14
	11	39

ease is pulmonary valvular stenosis, or tricuspid stenosis and insufficiency. Without treatment the disease is chronic and eventually fatal.

The systemic symptoms of the syndrome result from the release of excessive amounts of serotonin (5-hydroxytryptamine)³³ and bradykinin³⁷ into the systemic circulation. The liver converts most of the normal amount of serotonin from the portal circulation into 5-hydroxyindole acetic acid (5-HIAA) which is excreted in the urine. In the presence of carcinoid tumors the 5-HIAA excretion rises many times above normal levels.⁵⁰

In addition to the effects of excessive serotonin production, the patient may show signs of deficiency of niacin and protein. All but a small proportion of tryptophan normally is used in the synthesis of niacin and protein. The carcinoid tumor, and especially its metastases, may divert as much as 60 per cent of the available tryptophan to serotonin synthesis resulting in a deficiency of products formed by the normal pathway.²⁸

Not all carcinoid tumors produce serotonin. Two types of cells with granules having an affinity for silver may be involved. One, the *argentaffin* cell produces serotonin. The other, the *argyrophil* cell produces 5-hydroxytryptophan, the precursor of serotonin. Granules of argentaffin cells reduce silver salts in alkaline solution, while those of argyrophil cells accept silver only after its reduction by an extrinsic agent.¹⁰ In addition to the histochemical differences, the two types of cells can be distinguished by electron microscopy.⁸ Rectal carcinoids appear to be entirely of argyrophil, or non serotonin-producing cells, hence do not produce the carcinoid syndrome.⁸ Carcinoids of both types have been described from the appendix.¹⁸ Carcinoid tumors of Meckel's diverticulum have not been studied histochemically, but it is probable that both argentaffin and argyrophil cell tumors exist.

Syndrome Production

Three circumstances must be present for a carcinoid tumor of the gastrointestinal tract to produce the carcinoid syndrome:

- 1) The tumor must arise from serotonin-producing (argentaffin) cells.
- 2) It must be malignant.
- 3) It must metastasize beyond the area drained by the portal vein.

The presence of the carcinoid syndrome in patients with metastases to the liver indicates that there is insufficient liver parenchyma in the circulation distal to the tumor to convert effectively the serotonin produced. In a patient described by Gardner and his colleagues²³ the entire left lobe of the liver was dif-

fusely infiltrated with the tumor while the primary lesion in the ileum measured only 0.2 by 0.2 cm.!

The primary lesion in Meckel's diverticulum is usually small and is not invasive. Unless the lesion lies near the mouth of the diverticulum, simple diverticulectomy is sufficient. The mesenteric lymph nodes must be carefully examined for possible metastases. If there is doubt, the lymph nodes, mesentery and a segment of intestine above and below the diverticulum should be resected.

In contrast to the primary lesion, carcinoid metastases in the liver and lungs rapidly become widely disseminated and effective surgery is probably impossible. In one patient the entire left lobe of the liver was resected but the remaining lobe was filled with metastases within a few months.²³

Summary

1. A case of carcinoid tumor of Meckel's diverticulum is reported and 49 cases from the literature are reviewed. Although carcinoid tumors of this organ are not common, the infrequency of the diverticulum together with its short length makes the incidence of tumors very high in comparison with the rest of the gastrointestinal tract. Carcinoid tumors are the most common neoplastic lesions of the diverticulum.

2. Eighty per cent of carcinoid tumors of Meckel's diverticulum are found in males, most of whom are between 50 and 69 years of age.

3. Metastases occurred in 11 of the 50 tumors. Those in women metastasized more frequently than those in men. Frequency of metastasis does not correlate with patient's age or the size of the primary lesion.

4. The carcinoid syndrome was reported to have been present in six of the patients whose tumors had metastasized to the liver.

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Dysphagia and a Lesion in the Lower Esophagus

WILLIAM WHITAKER, M.D. and ELIZABETH HADLEY, M.D., *Atlanta**

DR. WILLIAM WHITAKER: This is the barium swallow of a 70-year-old female who gives a history of three months of dysphagia associated with dull substernal discomfort. The patient stated that food would "stick in the lower esophagus," however, there was no difficulty in swallowing liquids. The patient also has angina pectoris. There has been no weight loss. Dr. Hadley, what do you think of these films? (Figure 1)

Dr. Elizabeth Hadley: The esophagus appears normal, except for its most distal portion. There appears to be a rigid narrowing of the esophagus at the level of the cardia. On none of the films do I see evidence that this area is distensible.

There appears to be some slight irregularity of the gastric fundus near the cardia, which is highly suggestive of an esophageal carcinoma. The possibility of an inflammatory lesion with stricture formation would have to be considered. Early achalasia would seem unlikely in view of the recent onset in this patient of a stated age of 70 years. However, this configuration, combined with fusiform narrowing or "beaking," would be compatible with the configuration in achalasia.

Dr. H. S. Weens: You say that there is an abnormality in the lower esophagus and also there appears to be some abnormality in the gastric fundus?

Dr. Hadley: Yes, I believe that the fundus is slightly deformed. I would strongly be suspicious of carcinoma of the fundus of the stomach which is invading the distal esophagus.

Dr. Whitaker: The patient had esophagoscopy which demonstrated obstruction at 40 cm. with intact mucosa and this examination was not diagnostic of the underlying lesion.

Dr. Hadley: Some of the films demonstrate a compressed barium tablet which stops at the level

of the obstructing lesion. This pill measures 12 mm. in diameter and was devised for the detection of occult neoplasms at this level, and also in other levels along the length of the esophagus. (Figure 2)

Dr. Whitaker: The patient underwent exploratory thoracotomy and did, in fact, have adenocarcinoma arising in the fundus of the stomach and invading the lower esophagus. The lesion was resectable and an esophago-gastrectomy was accomplished.

The gross specimen shows evidence of submucosal infiltration of the fundus of the stomach, extending into the submucosal portion of the distal esophagus.

Comment

The gastric cardia and fundus are quite difficult to evaluate radiographically. This area is well known to radiologists as a "blind" area. Not only can extensive lesions go unrecognized on routine gastroin-

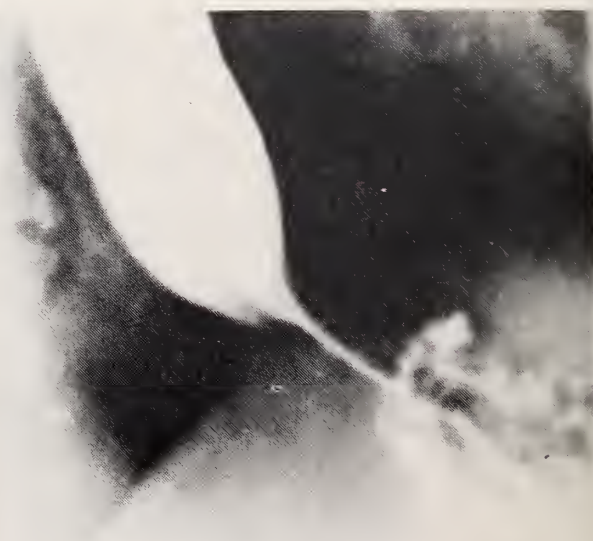


FIGURE 1

Spot film of lower esophagus demonstrating the fusiform constricting lesion in the distal esophagus near the cardia.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

testinal examinations, but on occasions the normal fundus may simulate a tumor mass. The most important lesion to detect in this area is adenocarcinoma of the fundus and cardia which invades the esophagus. Esophageal invasion results in dysphagia which may lead to an early diagnosis of the underlying neoplasms.

A 12.5 mm. compressed barium tablet has proven of value in detecting organic obstruction in the esophagus which may not be detected by conventional means. This has been used primarily to detect inflammatory strictures of the esophagus and to evaluate the diameter of the Schatzki ring, however, it has been pointed out that the pill may also prove of value in detecting occult neoplasms such as the case presented here.

Emory University 30322

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FIGURE 2

Upper G.I. film, the arrow points to a 12.5 mm. compressed barium tablet which is held up at the site of obstruction in the lower esophagus. The irregularity of the cardia, representing infiltrating carcinoma is also demonstrated.

TENNIS PLAYERS!!

Medical Association of Georgia Annual
Tennis Tournament

Dates: Men's Tournament, Thursday, May 10, 1973, 2 P.M.
Ladies' Tournament, Friday, May 11, 1973, 10 A.M.

Place: Augusta Country Club, Milledge Road

Entry Fee: \$1.00 Per Person

For further information contact:

(Men's Tournament)
Ronald F. Galloway, M.D.
1407-D Gwinnett Street
Augusta, Georgia 30902
Telephone: (404) 724-3586

(Ladies' Tournament)
Lois T. Ellison, M.D.
Medical College of Georgia
Augusta, Georgia 30902
Telephone: (404) 724-7111, Ext. 511

(CUT OFF AND MAIL TO CHAIRMAN)

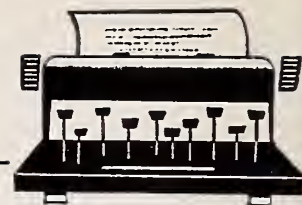
ENTRY FORM

NAME:

SEX:

FEE (\$1.00) Enclosed Will Pay at Tournament

Return to: Ronald F. Galloway, M.D.
1407-D Gwinnett Street
Augusta, Georgia 30902



Welcome to Augusta!

THE RICHMOND COUNTY MEDICAL SOCIETY considers it an honor to be your host for the 119th Annual Session of the Medical Association of Georgia in Augusta on May 10-13.

We hope that you will take the opportunity to enjoy our city's hospitality and beauty during your stay. For the history buff, there has been some restoration of historic sites in downtown Augusta; and the "White House," "Meadow Garden" and examples of Sand Hill cottages are our prides. Spring flowers are timed to bloom for the Master's Tournament, but the scenic routes through Augusta are pretty most any time of the year. If you like a busman's holiday, the new University Hospital is the largest community hospital in the state, and Mr. George Little, the administrator, likes to show it off. Recreational activities are available for the leisure hours between sessions at various clubs and community facilities.

This is "Homecoming" for M.C.G. Alumni. The campus has blossomed forth and is expanding in all directions. Fraternities are still thriving at M.C.G.—but try to visit your old lodge house.

We look forward to seeing you at the Social Hour before the President's Banquet on Saturday, May 12.

Ya'll come!

*Luther M. Thomas, Jr., M.D.
President
Richmond County Medical Society*

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

**Saturday, February 10, 1973
Sunday, February 11, 1973**

Benevolent Foundation: Approved retaining of present structure and payment of taxes as required.

Interspecialty Council: Received report on meeting of Interspecialty Council which recommended several changes in Georgia Medical Care Foundation and its relationship to the MAG Peer Review Committee.

MAG Headquarters Building: Authorized investigation of possibility of purchasing land immediately adjacent to MAG Building.

Abortion: Approved a statement to be sent to all members indicating: (1) MAG's concern for health care of Georgians; (2) the inherent risks of abortion as an operative procedure; (3) the necessity of abortion being performed in a properly equipped hospital or clinic; and (4) that only qualified Doctors of Medicine should perform abortions.

Legislation: Voted to oppose bills seeking to (1) change the names of state medical facilities; (2) allow informal admission procedures to state hospitals; (3) establish Certificate of Need for health institutions; and (4) include chiropractors under all health and accident insurance.

Regional Medical Program: Received report on President Nixon's proposed HEW budget which reflects a phase-out of RMP in Fiscal Year 1974.

PSRO: Suggested development of plans for workshop on seminar on PSRO for key men interested in peer and utilization review from component county medical societies.

Next Meeting: March 10-11, DeSoto Hilton, Savannah.



COLOSTOMY—TO IRRIGATE OR NOT TO IRRIGATE

WILLIAM C. MCGARITY, M.D.,* *Atlanta*

SINCE APPROXIMATELY 50,000 colostomies are being established in patients throughout the country annually, colostomy care has become a major problem. A colostomy is a distressing experience in the early postoperative period, but most patients adjust as they learn to handle the new system effectively. There is no single way to properly manage all colostomies.

Because the colostomy does not have a sphincter to stop the passage of a stool, patients have no control over their bowel movements. Some with a descending or sigmoid colostomy find that by eating selected foods at specific intervals, an evacuation of the colostomy at a time convenient to them is possible; however, this is the exception, and many colostomies require irrigation on a regular basis.

A collecting device is sometimes necessary as many factors are involved in the colostomy stoma action. Some patients use pouches for security and "peace of mind," while others may require only a gauze pad for protection.

The decision to irrigate or not to irrigate a colostomy depends on the following factors: (1) the site of the stoma or the length of the large intestine above the colostomy; (2) the personal feelings about the colostomy; (3) the age and competence of the individual; (4) the development of complications of the stoma; (5) the presence of disease of the colon; and (6) whether the colostomy is temporary or permanent.

Irrigations of an ascending or right colostomy are not usually satisfactory because the stool is liquid or semi-liquid. In this situation, irrigations will add to the liquid stool and the patient will have continuous fecal discharge. These patients should be taught to use the proper ostomy equipment to prevent skin irritation and contain output. Occasionally, however, a person with an ascending or right colostomy will have semi-solid stool, and the colostomy can be regulated with daily irrigations.

Most right transverse colostomies are also difficult to regulate with irrigations because of the short proximal colon containing semi-liquid stool. On the other hand, irrigation of the left transverse colostomy is usually satisfactory because the feces in this area is becoming semi-solid. Daily irrigations or irrigations on an every-other-day basis should be tried to determine which program is more suitable to the individual's needs.

Consider Preoperative Habits

The evacuation of most descending or sigmoid colostomies, where the stool is well formed or solid, is easy to accomplish with irrigations. The preoperative habits

* Professor of Surgery, Emory University School of Medicine; Chief of Surgery, Emory University Hospital; and Director of Enterostomal Therapy Training Program, Emory University, Atlanta, Georgia.

of the colon, such as previously normal daily bowel movements, diarrhea, constipation and laxative dependency, will determine the frequency of irrigations. Those who can regulate their colostomies with irrigations are more successful in reducing the number of colostomy movements and the amount of gas and odor. Although, a few patients who had regular bowel habits preoperatively may have regular evacuations of the sigmoid colostomy without irrigations.

There are individuals who have difficulty adjusting to a colostomy. Some may refuse or be afraid to do the irrigations. He may prefer not taking the time for the procedure and, thus, will allow nature to take its course. These factors can be eliminated with adequate education and rehabilitation.

Irrigations should not be permitted for some of the aged or incompetent individuals, as the risk of complications is higher in this group. One of the most serious complications is perforation of the colon from the catheter which can occur in the abdominal wall or in the free peritoneal cavity. The use of an irrigating cone can eliminate this hazard. If a patient has physical limitations, a member of the family can be taught to assist in the irrigations; however, this may not be convenient for the patient or for a member of the family.

Complications of the stoma, such as prolapse and peristomal hernias may interfere with or contraindicate irrigations. Stenosis of the stoma requires laxatives to produce liquid stool and daily irrigations to prevent fecal impactions. Disease of the colon increases the risk of complications from irrigations. Extensive diverticulosis, radiation colitis, and inflammatory diseases of the colon just proximal to the stoma could present hazards such as perforation of the colon.

As a general rule, patients with temporary colostomies are not advised to irrigate. By the time they can adapt to the procedure or become regulated, closure of the colostomy is performed.

It is essential that the patient learn to perform the irrigations as soon as possible. The physician should determine the patency of the stoma and how soon the irrigations should be started in the postoperative period. Before the patient is ready for discharge from the hospital, he should be instructed in skin care and the use of proper equipment, and he should be capable of doing his colostomy irrigations. A well-managed colostomy allows for normal activity of the patient.

Training Program Begun

Recently, an Enterostomal Therapy Training Program was established at Emory University through the combined efforts of the Emory University School of Medicine, Emory University School of Nursing and the Division of Nursing of Emory University Hospital. Funds have been provided by the American Cancer Society to develop this program. There are only five certified centers in the United States, and the program at Emory is the only one in the Southeast. There are three certified enterostomal therapists on the staff of the Emory program. This program will provide training for registered nurses from Georgia and other areas of the country who will provide adequate pre- and postoperative ostomy care, and help in the rehabilitation of the ostomy patient and his family. It is the goal of this program to provide the trained personnel required to properly prepare the steadily increasing number of individuals with ostomies to resume their normal activities.

*Emory University
1365 Clifton Road, N.E. 30322*



POLYARTERITIS NODOSA—AN ENIGMATIC DISEASE

J. P. JONES, M.D.,* *Atlanta*

POLYARTERITIS NODOSA (periarteritis nodosa, essential polyangiitis, panarteritis nodosa, necrotizing arteritis) is a primary disease of the vascular system of unknown etiology with a myriad of clinical manifestations. The disease as a clinical syndrome was first recognized and reported in 1866 by Kussmaul and Maier.

The incidence of polyarteritis nodosa is difficult to determine. Most series are autopsy studies and vary from two cases in 3000 autopsies to six cases in 19,242 autopsied cases. It is most often seen in the fourth decade and occurs two to three times more frequently in males than females. It has been reported in the first days of life and in the ninth decade.

Clinical Manifestations

The initial manifestations are so varied that there is no "typical" clinical presentation. Frequent early complaints are myalgia, arthralgia, anorexia, fatigability, weight loss, headache, chilliness, weakness and fever. Fever is present in most cases; a few patients never have fever. In 607 cases, fever occurred in 68 per cent. It was low grade, continuous or intermittent. It was frequently septic and out of proportion to the patient's clinical appearance. Prolonged afebrile periods were not uncommon.

The emphasis on the triad of fever, abdominal pain and hypertension in a young man as being typical of polyarteritis is misleading. A majority of the patients fail to show this picture.

Polyarteritis, with its protean clinical manifestations, is frequently unrecognized during life. It has been confused with typhoid fever, cholecystitis, trichinosis, appendicitis, dysentery, encephalitis, meningitis, polymyositis, tuberculosis, peripheral neuritis, rheumatoid arthritis, gastroenteritis, acute nephritis, nephrosclerosis and septicemia, to mention a few of the more common misdiagnoses.

Pathological Manifestations

Pathologically the disease process chiefly involves the small arteries and arterioles in a segmental fashion. All the layers of the vessel wall are involved. The early lesions consist of degenerative changes in the media, with edema and a thready fibrinous exudate containing leukocytes, called fibrinoid necrosis. This is followed by an acute inflammatory stage with infiltration of the media and adventitia with leukocytes and occasionally eosinophils, lymphocytes and plasma cells. This results in necrosis of the media and elastic interna which becomes fragmented and stretched. Subendothelial reactive proliferation occurs, resulting in occlusion of the vessel by secondary thrombosis. The weakened vessel wall may result in aneurysmal dilatation, rupture and hemorrhage.

This stage is followed by proliferation of fibroblasts from the adventitia into the inflammatory zone with an increase in lymphocytes and plasma cells. This may

* Prepared at the request of the committee on Professional Education of the Georgia Heart Association. Dr. Jones is a Fellow in Cardiology at Emory University School of Medicine.

be followed by a healing stage in which there is thickening of the vessel wall due to intimal proliferation and subintimal, medial and periadventitial fibrosis. The veins are rarely involved. In 230 cases at the Armed Forces Institute of Pathology, arteries were involved in the following order: renal, coronary, adrenal, pancreatic, mesenteric, hepatic, splenic, testis, lungs, skeletal muscle, gall bladder and brain. The disease process of the vessels results in infarction of the organs subserved by the involved vessels.

Diagnosis

Diagnosis on clinical grounds is difficult. Muscular aches, peripheral neuropathy, abdominal pain, evidence of renal disease or hypertension in a setting of leukocytosis, fever and weight loss are the predominant clinical features; however, variations are frequent. Eosinophilia is not common unless there is an associated allergic manifestation such as asthma. The process may be acute, sub-acute, or chronic. Periods of remission of varying length may be interspersed with a constellation of seemingly unrelated findings.

Diagnosis is confirmed by biopsy of various organs, most often skin and muscle, or testes. Muscle biopsies should be taken from tender muscles. Recently angiography has been utilized to demonstrate aneurysms or zones of necrosis within the parenchyma of various organs in patients with polyarteritis. Demonstration of the typical aneurysms in the proper clinical setting is virtually diagnostic.

Presently the only therapy of any value is the long-term use of corticosteroids. The initial dosage should be high with subsequent reduction of the daily maintenance dosage to that which suppresses inflammation.

Emory University School of Medicine 30322

'REALITY ORIENTATION' HELPS OLDER VETERANS REDUCE MEMORY LOSS

Pioneering a new treatment called "reality orientation," the Veterans Administration hospital in Tuscaloosa, Ala. has been able to clear the minds of many older veterans who no longer knew who or where they were.

Dr. Lars P. Peterson, psychologist from Tuscaloosa, reported on the treatment at the American Psychological Association meeting in Honolulu, Hawaii.

In its most simple form, the technique involves repetitive identification of the patient by name, repeating the name of the hospital or nursing home, the day of the week and month, etc.

The original disorientation and behavioral changes that bring loss of friends, chronic physical illness, severe mental symptoms or even death, may have been brought on by some abrupt change in his life. Such a change could be the death of his wife, retirement or a slight stroke.

Dr. Peterson said the approach is effective for many formerly thought to be suffering from irreversible senility and other types of brain disorders usually associated with aging. The approach is now being used in many VA hospitals. It was found that memory loss in many cases was due to psychological factors instead of physical deterioration.

The treatment was originated by Dr. James C. Folsom, former director of VA's Tuscaloosa hospital and

now deputy commissioner for the Alabama Department of Mental Health. He was on the faculty of the Menninger School of Psychiatry from 1953 to 1960.

GEORGIA NATIVE HEADS PFIZER, INC.

New York based Pfizer, Inc. has announced the election of Edmund T. Pratt, Jr., 45, Savannah native, as chairman of the board and chief executive officer. He succeeds John J. Powers, Jr. who is retiring after 32 years with the billion dollar company.

Pratt comes to his new position with a varied background in business and government. Graduating with degrees in electrical engineering and business, he was a salesman, controller, government official and international division president before entering the ranks of overall corporate management at Pfizer.

He was graduated from Duke University and Wharton School of Commerce and Finance of the University of Pennsylvania. He served in the U. S. Navy during World War II, returning from 1952 to 1954 as intelligence officer. Later he worked for IBM, served in the Kennedy administration as assistant secretary for financial management of the army and came to Pfizer in 1964.



CHARITABLE INCOME AND REMAINDER TRUSTS UNDER THE TAX REFORM ACT

WILLIAM LINKOUS, JR. and L. PHILLIPS RUNYON, III, *Atlanta**

OF ALL THE CHANGES brought about by the now infamous Tax Reform Act of 1969, few are more significant, yet less understood, than those affecting gifts in trust to charity.

In the past such trusts would typically provide that trust income be paid to the widow for life; then at her death, the trust income or the trust assets would go to charity. This device enabled persons with moderate to large estates to confer a benefit upon their families and, at the death of the persons benefited, to make contributions to charity for which the taxpayer or his estate received tax deductions based on the actuarial value of the interests passing to charity. Such trusts have been referred to as "charitable income trusts" (where income only is paid to the charity) or "charitable remainder trusts" (where the trust assets are ultimately delivered over to the charity).

Prior to 1969 there were very few formal restrictions on the terms of such trusts, the various charitable deductions being allowed as long as the interest passing to charity was "ascertainable" with some degree of certainty and was not "so remote as to be negligible" due to the presence of unlikely contingencies.

Standards Led to Abuse

Not surprisingly, these somewhat amorphous standards soon led to abuse. The drafters of the Tax Reform Act were particularly concerned with the possibility that there might be little correlation between the value claimed as a deduction for a charitable remainder and the ultimate amount that the charity would in fact receive. Since remainder trusts often provided that the charity's interest was conditioned upon the happening of remote events or that the principal of the trust could be invaded as necessary for the benefit of the non-charitable life beneficiary, these concerns were very real. To remedy this situation, Congress devised the so-called "charitable remainder unitrust" and "charitable remainder annuity trust," emphasizing in doing so that these are henceforth the *only* means of obtaining tax deductions as to income or property passing to charity after the intervening term of benefit to a non-charitable beneficiary.

Although the new unitrusts and annuity trusts must contain a number of highly technical provisions in order to ensure qualification, their basic concept is relatively simple. Thus, a unitrust is a trust which provides for payment of a fixed percentage (not less than 5 per cent) of the value of the trust assets to an individual beneficiary during each year of his life or for a term of years not exceeding twenty, with

* Prepared at the request of The Medical Association of Georgia. Mr. Linkous is a partner and Mr. Runyon is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

the remainder of the property after the expiration of the non-charitable interest to be paid to or held for the benefit of a qualifying charity.

An annuity trust is identical to this in every respect except that each year, instead of a percentage of the value of the trust assets, the non-charitable beneficiary receives a fixed dollar amount of at least 5 per cent of the initial value of the assets. Payments under both trusts may be made from income, but if income is not sufficient, principal must be used to make up the difference. Aside from this limited use of principal, the trusts may not provide for invasions of principal for the non-charitable beneficiary nor may they condition the interest of the charity upon the performance of any act or the occurrence of any event other than the natural expiration of the non-charitable term.

Flexibility Still Possible

Although this picture certainly gives the impression that all room for individuality has been legislated out of charitable remainder trusts, some degree of flexibility is still possible. Multiple non-charitable beneficiaries may be used, either concurrently or consecutively, as long as the total amount payable from the trust meets the 5 per cent minimum requirement. Thus, a trust could provide for payment of 5 per cent of the asset value to one family member for life and then upon her death to another for life, or the percentage amount could be divided equally between a group of people until the death of the survivor. Moreover, the trustee can be given the power to "spray" or "sprinkle" the yearly percentage or amount among a group of persons according to their needs.

One power which can be reserved by the person establishing the trust is the testamentary power to revoke or terminate the interest of any non-charitable recipient. This, for example, enables him to make a gift of the unitrust or annuity amount to his wife without incurring a gift tax because of the retained power of revocation. In addition, the amount payable under a unitrust only can be modified so that the life beneficiary receives solely the amount of income earned by the trust up to the percentage of the assets specified in the instrument.

A good example of how a unitrust or annuity trust can be used to achieve a number of desired goals is presented by the individual who desires to sell land or other property which has greatly appreciated in value and on which a large capital gain would otherwise be recognized. By transferring the property to a charitable remainder unitrust and providing that only the trust income up to some designated unitrust percentage is to be paid to the owner and his wife until the death of the survivor, he can avoid a significant portion of the tax burden.

First of all, he will receive a current income tax deduction for the actuarial value of the charity's remainder interest computed on the basis of the appreciated value of the contributed property. When the property is later sold by the trust, the capital gain will not be taxed to anyone since the taxpayer, for purposes of determining the gain, will be a tax-exempt charitable trust. The owner of the land himself will pay income tax solely on the amount of income generated each year up to the specified percentage, and if he has retained the testamentary power to terminate the interest passing to his wife, he will pay no gift tax on the interest that she will receive as a life beneficiary.

Novel Idea Reverses Roles

The final and most novel charitable trust added by the Tax Reform Act of 1969 is the so-called "charitable income interest trust," also known as the charitable "lead" or "front-end" trust. While this device is virtually untried as yet, it may well be the most attractive of all from a long-range planning standpoint.

In a charitable lead trust the parts of the life beneficiary and remainderman in a unitrust or annuity trust are simply reversed. A charity receives an irrevocable right to receive a fixed percentage or a fixed dollar amount of the trust assets each

year, payment being made for the life of one or more named individuals or for a term of years. Upon the expiration of the charity's interest, the remainder of the property becomes payable to one or more non-charitable beneficiaries. During the time when payments are being made to the charity, excess income over the fixed percentage or guaranteed annuity amount may not be paid to a private individual, although they may be paid to a charity. As with unitrusts and annuity trusts, a large number of additional technical provisions must be included in the trust in order to qualify it for the various charitable deductions.

Upon creation of such a trust, the person receives an income tax deduction for the present value of the amounts receivable by charity as long as he would be taxable on the trust income absent the deduction. In the estate and gift tax areas, charitable lead trusts allow a person to provide principal for members of his family at minimal gift and estate tax cost. Understandably, the larger the fixed percentage or annuity amount and the longer the term, the smaller the taxable portion becomes. Moreover, if the assets of the trust are such that they can earn more or appreciate faster than the rate at which payments are being made to the charity, the amount of principal receivable by the family can continue to increase without further estate or gift taxes being imposed.

New Devices Require Planning

While these remarks have attempted to cover the salient features of charitable income and remainder trusts, it cannot be overemphasized that these new devices require much more careful planning and concern with technical requirements than any similar trusts under prior law. Certainly anyone who now has a charitable trust of the traditional variety should consult his tax advisors and review its provisions in light of the new requirements, and anyone now embarking on any sort of charitable gift or bequest in trust should undoubtedly seek professional assistance. This article is in general terms only and does not attempt to cover the large body of technical rules which must be followed. Also, as we have seen, the tax laws are revised from time to time and what has been said here may not apply at some future date.

Eleventh Floor

C & S National Bank Building 30303

GEORGIA DIABETES ASSOCIATION PROVIDES YOUTH CAMP

At its statewide camp committee meeting in Atlanta in January the Georgia Diabetes Association began detailed planning for the 1973 session of the GDA YOUTH CAMP, which will be held the first two weeks in July. This camp will again be held at the Atlanta Baptist Assembly facilities north of Atlanta, in a setting overlooking the Chattahoochee River between Sandy Springs and Roswell—just off Highway 400 North on Northridge Drive, Dunwoody. Any diabetic child between 9 and 16 is eligible, however, enrollment is limited to 100 campers.

A new feature this year will be the institution of a counselor-in-training program for diabetic boys and girls 16 or older who are interested in this phase of

camp activity. A pre-camp orientation session will be held for all staff members under the supervision of Rev. John Haynes, camp director, assisted by representatives of the medical/nursing/dietetic staff plus the program and counselor directors.

Prospective campers, their families, and GDA friends are invited to an Open House at the camp Sunday, April 15, between 2 and 4 p.m. to meet staff representatives and look over the facilities.

Additional information and applications may be secured by writing to: Camp Secretary, GDA Youth Camp, Suite 5525, 3312 Piedmont Rd., N.E., Atlanta, Ga. 30305.

THE ASSOCIATION



NEW MEMBERS

Blackshear, Joseph R.
Active—Dougherty—ER
Phoebe Putney Memorial Hospital
Albany, Georgia 31701

Brown, Algie C.
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1365 Clifton Rd., N. E.
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Dawson, Jack E., Jr.
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Elliott, Ralph A.
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SOCIETIES

The **Camden-Charlton Medical Society** has chosen Carl Drury of Kingsland and St. Marys as president for the upcoming year. Named as secretary was R. Roy McCollum of Kingsland. Clarence H. Harper of Folkston and G. W. Barker of St. Marys will serve as vice chairmen.

PERSONALS

Second District

Charles Gillespie, Albany, praised Mitchell County commissioners for their early financial support of the MAST (Military Assistance to Safety and Traffic) program when he was guest speaker at the Camilla Rotary Club in January. This program of military and civilian cooperation will soon involve 20 new bases after starting in Texas and Montana. Through MAST, helicopters are used in emergency situations involving civilians.

Albany's **Otis J. Woodard, Jr.** has been elected president of the medical staff of Phoebe Putney Memorial Hospital for 1973. His term began January 1 along with **Drs. L. T. Crimmins**, vice president, and **William F. Harper**, secretary.

Third District

The Americus City Council has appointed **James G. Herron** as city physician.

Fifth District

Marguerite Louisa Candler was honored as Atlanta's 1972 Woman of the Year in the professions at a

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Wegener's Granulomatosis
See page 101



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Cover

The nodular lesions found with Wegener's Granulomatosis are spotlighted on the April cover and in an article by Doctors Speir and Hayes on page 101. Layout by Atlanta artist Bob Hamill.

Wegener's Granulomatosis is a relatively uncommon disease which before the advent of effective therapy was almost uniformly fatal. Now, however, long-term remission and even cure follows treatment with cytotoxic drugs, so that early recognition of this disease by primary care physicians is mandatory.

Wegener's Granulomatosis

WILLIAM A. SPEIR, JR., M.D. and LLOYD E. HAYES, M.D.,* Augusta

WEGENER'S GRANULOMATOSIS was first described by Klinger in 1931, and was more clearly elucidated by Wegener in 1936 and 1939. Classically, the disease begins with upper respiratory tract involvement and progresses rapidly to involve the lungs and kidneys. Other organs may be involved, particularly the joints, skin, middle ear and orbital tissue. The disease is characterized pathologically by the presence of giant-cell granulomas and necrotizing angiitis.

In the era before immunosuppressive or cytotoxic therapy, the disseminated form of the disease was almost invariably fatal, usually within six months. Remission in untreated patients, if it did occur, was extremely rare.

Since the early 1960's a number of reports describing a localized pulmonary form of the disease have appeared. While this localized form may ultimately progress to widespread involvement of other organs, in many cases it remains limited to the lungs.

The following two cases, recently seen at the Eugene Talmadge Memorial Hospital, illustrate the clinical presentation and course of the disseminated and localized pulmonary forms of Wegener's Granulomatosis.

Case Reports

A 54-year-old white housewife was admitted to the Eugene Talmadge Memorial Hospital in June, 1971, with a three year history of bilateral otitis

media and chronic sinusitis, resistant to treatment. Approximately three years prior to admission, she had bilateral conjunctivitis and iritis, with proptosis of the right eye. She was treated with prednisone, 60 mgm daily for one year, with complete resolution of the eye problem, although she continued to have chronic sinusitis.

For two years prior to admission, she had recurrent pulmonary infections with cough, hemoptysis and pleuritic chest pain. Two months before admission, she developed a chronic productive cough, occasional hemoptysis and migratory arthralgias. A chest x-ray in May, 1971, showed bilateral nodular lesions (Figure 1, upper left), and she was referred to the Eugene Talmadge Memorial Hospital for evaluation.

Chest film on admission showed cavitation of the nodular lesions (Figure 1, upper right). Sinus films showed membrane thickening of the left maxillary sinus. Pertinent laboratory data included a hemoglobin of 9 gm per cent, white blood cell count of 8,400, urinary protein of 2+, serum creatinine of 4.6 mgm per cent and negative rheumatoid factor.

A left renal biopsy showed focal necrotizing glomerulitis. A lung biopsy obtained through a left thoracotomy was histologically consistent with Wegener's Granulomatosis, showing necrotizing arteritis with infarction of lung tissue and giant-cell formation (Figure 2).

Her renal function continued to deteriorate; serum creatinine increased to 6.7 mgm per cent with a creatinine clearance of 10 ml/min. Pulmonary symptoms also progressed accompanied by radio-

* From the Division of Pulmonary Diseases, Department of Medicine, Medical College of Georgia in Augusta. Presented in part at the Georgia Regional Meeting of The American College of Physicians-American Society of Internal Medicine, Nov. 22, 1971 in Augusta.

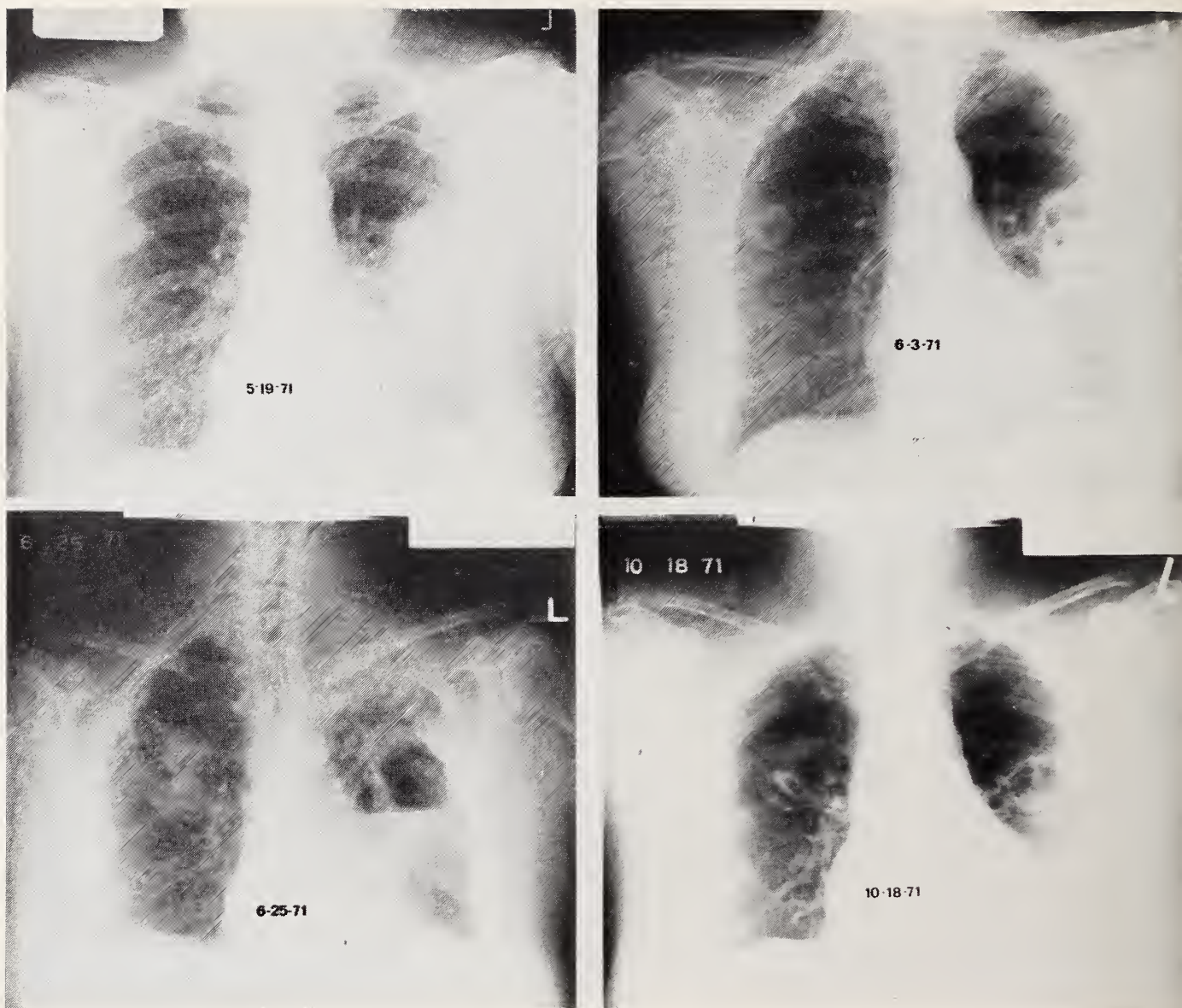


FIGURE 1

Serial chest films showing bilateral nodular lesions prior to admission (upper left). Cavitation of the nodular lesions on admission film (upper right); progressive wor-

sening (lower left); and, clearing following treatment with chlorambucil and prednisone (lower right).

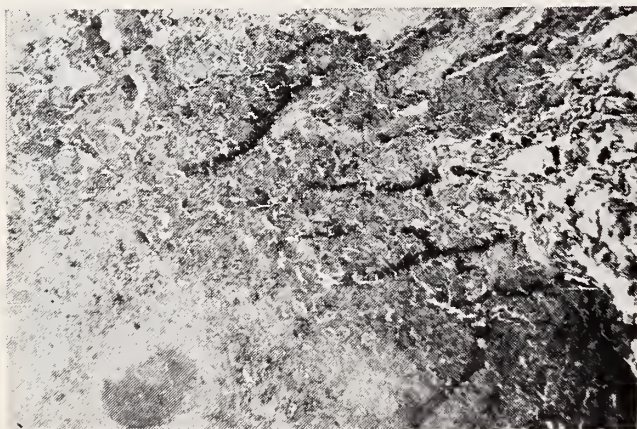


FIGURE 2

Lung biopsy showing necrotizing arteritis, infarction of lung tissue and giant-cell formation.

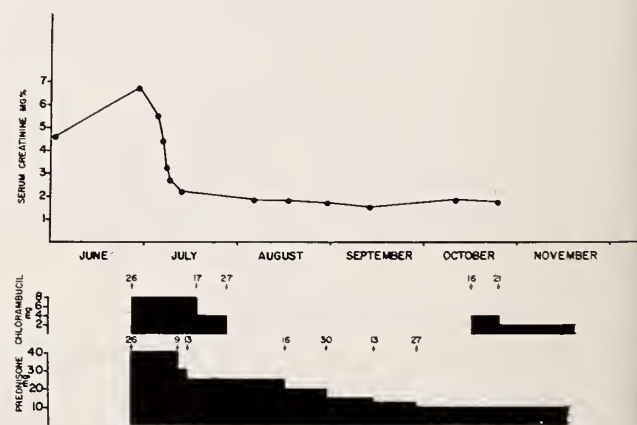


FIGURE 3

Serum creatinine levels showing response to therapy with chlorambucil and prednisone. Other clinical parameters showed a similar response.

logical evidence of deterioration (Figure 1, lower left). Therapy with chlorambucil 8 mgm and prednisone 40 mgm daily was begun. The patient showed striking clinical improvement (Figure 3). Chlorambucil was discontinued after one month because of leukopenia and thrombocytopenia and the patient was discharged on prednisone alone. She was admitted for reevaluation three months later. Chest x-ray showed definite clearing (Figure 1, lower right). Serum creatinine had decreased to 1.8 mgm per cent, with creatinine clearance of 24 ml/min. Therapy with chlorambucil was re-instituted and she was discharged. Since discharge in October, 1971, she has been followed as an outpatient and has continued to do well.

A 23-year-old black housewife was admitted to the Eugene Talmadge Memorial Hospital in March, 1971 because of increasing dyspnea. Chest x-ray showed diffuse, bilateral nodular and fibrotic lesions, with cavitation of several of the nodules (Figure 4).

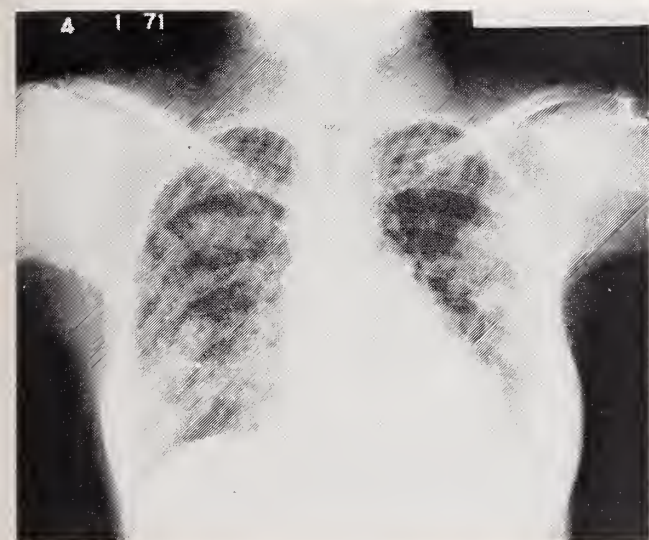


FIGURE 4

Chest film showing diffuse bilateral nodular lesions.

There was no evidence of upper respiratory tract or renal involvement. Rheumatoid factor was negative. Spirometry showed a vital capacity of 1.48L, which was 46 per cent of predicted, and was consistent with a severe restrictive ventilatory impairment. Past history revealed the patient had been admitted to the University Hospital in San Diego, California in June, 1968 for evaluation of a seizure disorder which had been present and untreated since childhood. Chest film showed diffuse bilateral changes and an open lung biopsy was consistent with Wegener's Granulomatosis. She was treated with high-doses of prednisone for one year, with little clinical change.

Because of her increasing symptoms she was being considered for therapy with chlorambucil; however, she moved out of state and was lost to follow-up.

Discussion

Wegener's Granulomatosis is classified as one of the necrotizing angiitides (Figure 5). Although the relationship of these entities is uncertain, some form of common stimulus is a distinct possibility.¹

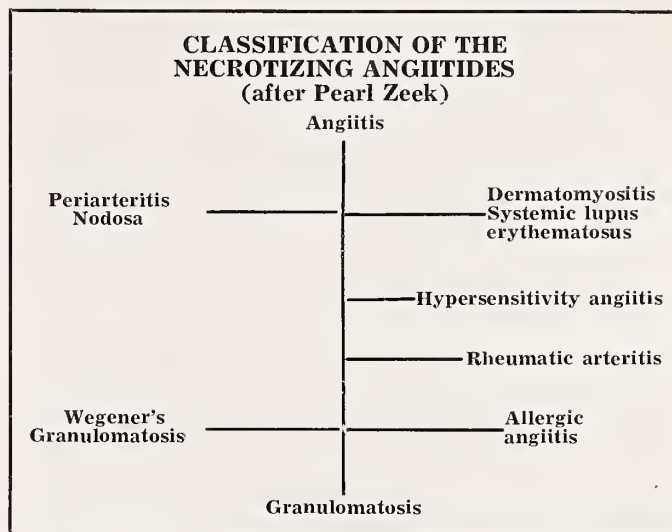


FIGURE 5

Modified from Cassan, S. M., et al.: *The Concept of Limited Forms of Wegener's Granulomatosis* (p. 376). *Am. J. Med.* 49:366-379, 1970.

The etiology of Wegener's Granulomatosis is unknown, however the typical granulomatous and angiitic lesions have many histologic features in common with allergic and hypersensitivity states.^{2, 3} The relationship, if any, to lymphomas is not known, however Reed-Sternberg-like cells are seen in some patients with Wegener's Granulomatosis, and certain drugs, such as diphenylhydantoin, can produce lymphomatous changes as well as hypersensitivity angiitis.

In recent years, there has been much interest in the localized forms of the disease. Most authors now consider lethal midline granuloma a localized variant of Wegener's Granulomatosis.^{2, 3} Byrd and his associates⁴ followed 10 patients with lethal midline granuloma for periods of up to 9½ years, and four of these patients developed the disseminated form of Wegener's Granulomatosis. Wegener's Granulomatosis limited to the lungs has been reported with increasing frequency;^{5, 6, 7} it usually runs an indolent course, and long-term survival has been reported in untreated patients. Occasionally, a focal necrotizing glomerulitis, indistinguishable from that associated with Wegener's Granulomatosis, and without other organ involvement, is seen. It is conceivable that this represents a limited renal form of the disease.⁸

Prior to the use of corticosteroids and cytotoxic drugs in the treatment of this condition, patients with the disseminated form of Wegener's Granulomatosis survived for an average of five months.⁹

With the use of high doses of corticosteroids, the average survival increased to about one year, although the response was variable and in many cases corticosteroids did not alter the progressive course of the disease.^{10, 11}

McIllvanie¹² reported the long-term survival of two patients with Wegener's Granulomatosis treated with chlorambucil in 1966 and since then numerous reports of the successful use of cytotoxic drugs, singly and in conjunction with corticosteroids,¹³ have appeared. The mechanism of action of these drugs in Wegener's Granulomatosis is not known; however, it seems likely that the cytotoxic effect, as well as immunosuppression, is involved. Both alkylating agents,^{14, 15} such as cyclophosphamide and chlorambucil, and antimetabolites,^{16, 17} such as azathioprine and methotrexate, are equally effective. The cytotoxic drugs seem to completely reverse the relentless course of the disease. Average survival with the use of these drugs has increased dramatically and very few treatment failures have been reported.

Medical College of Georgia 30902

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HIGHLIGHTS OF MAG COUNCIL MEETING

March 10-11, 1973

Finance: Approved payment of \$1,223 for partitioning of MAG Headquarters Office 1st floor lobby; transfer of \$4,000 from Quackery Committee to Legislative Committee budget; additional \$700 for actuary's retainer; advancing \$250 as matching funds for AMCC scholarships.

Insurance Program: Endorsed transfer of MAG member insurance plans from Life of Georgia to Southern Medical Association's program; instructed Insurance Committee to continue investigating comprehensive insurance package and major medical plan.

Constitution and Bylaws: Reviewed language change to restrict membership to county of dominant practice or one contiguous to it.

Newborn Insurance Coverage: Appointed Task Force to publicize need for coverage of newborn in all insurance policies written in Georgia.

Health Maintenance Organizations: Voted to oppose Georgia HB 998 which would allow formation of HMO's. Authorized working with Georgia's Congress-

men to eliminate objectionable features of Rogers-Roy bill for HMO's and for defeat of Kennedy Bill.

Health Careers Council: Recommended to Finance Committee additional funding for WAMAG in amount of \$5,000 for operation of Allied Medical Careers Clubs.

Georgia Medical Care Foundation: Received report of signing of peer review contract with Blue Shield of Atlanta.

Professional Standards Review Organization: Received report on planned PSRO Seminar scheduled for Macon Hilton Hotel, April 13-14.

Experimental Medical Care Review Organization: Instructed staff to notify all Specialty Societies of meetings of all EMCRO criteria development workshops.

Georgia Regional Medical Program: Authorized notification by letter of Georgia's Congressional delegation of benefit GRMP has been to Georgians.

Next Meeting: May 9, Richmond Hotel, Augusta.

The author feels that more surgeons should consider this procedure since it is relatively simple and very effective.

Prophylactic Clipping of the Inferior Vena Cava

MILTON F. BRYANT, M.D., *Atlanta*

I KNOW OF NO GREATER catastrophe than for a surgeon to perform an apparently successful operative procedure and then have the patient succumb to massive pulmonary embolism in the post-operative period. Some 50,000¹ patients die from this catastrophe in the United States each year indicating that pulmonary embolism is probably the most common lethal pulmonary disease in our country. The increasing frequency of pulmonary embolism is partially related to the large number of surgical procedures performed upon our older citizens and the increasing number of patients suffering severe trauma in automobile accidents.

Coon and associates¹ have shown that 50 per cent of fatal cases show no clinical evidence of venous thrombosis prior to embolization. If we cannot diagnose venous thrombosis in many patients prior to fatal embolism, we have no alternative but to turn our attention to prophylactic measures in an effort to prevent pulmonary embolism.

Preventive Measures

Most investigators have tried and concluded that anticoagulants are too hazardous for routine use. In addition, it has been stressed that anticoagulants do not have any effect upon existing thrombi and do not prevent detachment of clots. Alpha-tocopherol has been suggested² as being helpful in preventing post-operative venous thrombosis. Early ambulation, elevation of the foot of the bed and the use of elastic supports are measures used by most surgeons in an effort to prevent venous thrombosis. No one is sure how effective these measures are.

Since most venous thrombi (85 per cent) originate in the deep veins of the legs and pelvis, Homans³ suggested in 1934 that ligation of the inferior vena cava should be effective in preventing pulmonary embolism. Subsequently, many surgeons have ligated the inferior vena cava therapeutically to pre-

vent further embolization. Prophylactic ligation of the vena cava has been practiced by a few surgeons. There has been considerable discussion and argument over the incidence and severity of chronic venous insufficiency following ligation of the inferior vena cava. Some authors⁴ believe that with proper treatment chronic venous insufficiency presents little or no problem. Other investigators⁵ feel that chronic venous insufficiency is a real and frequently disabling problem following ligation of the inferior vena cava.

A number of surgeons^{6, 7, 8} have tried to develop methods of partially occluding the inferior vena cava so as to trap possible emboli and yet avoid the problem frequently encountered with complete obliteration of the inferior vena cava (Figure 1). DeWeese

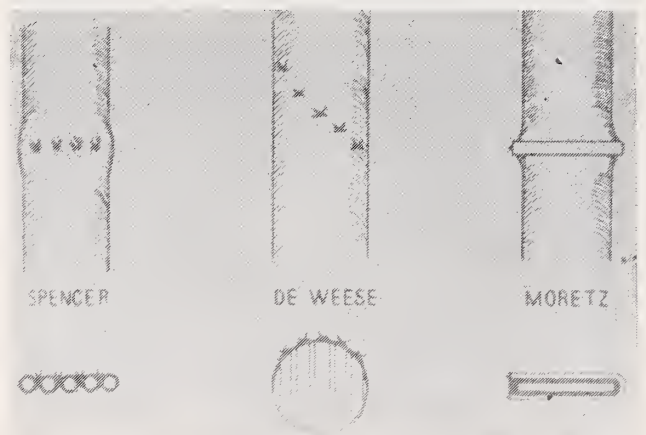


FIGURE 1

Various methods of partially occluding the inferior vena cava.

and Hunter⁹ in 1955 first suggested that these objectives could be accomplished by construction of a harp-like grid filter. Subsequently Moretz and his associates developed a plastic clip and Spencer devised the technic of plicating the cava. Many modifications of these technics have been developed and reported. All three technics are probably equally effective and

the particular technic used will depend upon the personal preference of the operating surgeon.

We have used the Moretz clip to partially interrupt the vena cava. This clip has a 3 mm gap, is easy to apply and is effective. Both jaws of the clip are smooth and can be inserted around the posterior wall without snagging and tearing the cava or a lumbar segmental vein. Recently Adams and DeWeese¹⁰ have developed a clip which has one smooth jaw that can be inserted around the posterior wall of the vena cava. The anterior jaw has teeth so as to compartmentalize the cava when the clip is closed. Clips with teeth on both jaws are somewhat difficult to insert beneath the posterior wall of the vena cava. The jaws of all clips should be sutured together to hold the clip firmly in place. Snap-on devices may become dislodged with coughing, sneezing or straining.

Many studies have shown that with partial interruption of the vena cava there is little or no pressure change distal to the clip and little or no change in blood flow across the site of partial interruption (Figure 2). Subsequent cavagrams have been performed after application of the clip and the cava re-

mains open with no development of collateral vessels.

It is felt that partial interruption should be carried out just distal to the renal veins. Separate ligation of the gonadal vessels is not necessary. However, if one is dealing with septic embolization the cava should be completely occluded and both gonadal veins ligated. The usual therapeutic clipping procedure can be carried out transperitoneally or retroperitoneally through a flank incision.

Collateral Vessels

One must not be misled into thinking that just because the inferior vena cava has been ligated that further pulmonary embolization cannot occur. Cavagrams have shown that large, and frequently huge, collateral vessels form around the site of ligation (Figure 3). The large collateral veins may carry emboli from the legs and pelvis. In general, it takes three to four months for these large collateral vessels to develop, but they have been demonstrated in every patient we have performed a cavagram upon who has had his cava ligated.

To date we have prophylactically applied 150 Moretz clips to the inferior vena cava of patients undergoing abdominal surgery for some other disease. One hundred twenty clips have been applied in pa-

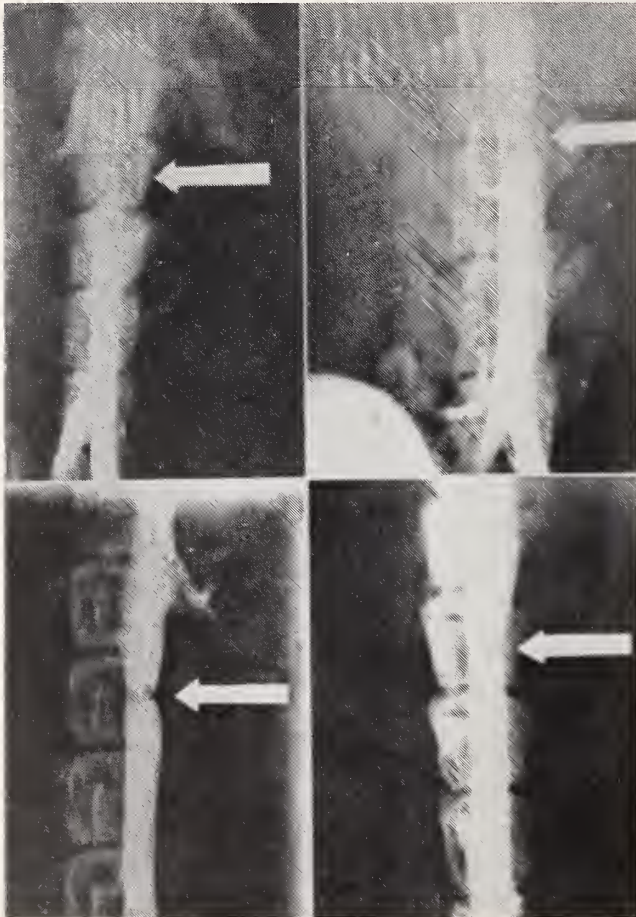


FIGURE 2

Vena cavagram showing no obstruction to flow after partial interruption of the vena cava.



FIGURE 3

Cavagram showing huge collateral vessels around the site of ligation.

tients having vascular surgical procedures—resection of aneurysm, visceral arterial surgery, renal artery surgery and surgery for aorto-iliac atherosclerotic obstructive disease. Fifteen clips have been applied in patients having colon surgery, eight clips in patients undergoing gastric surgery and seven clips in patients having a hysterectomy. None of these patients have had clinical evidence of post-operative pulmonary embolism and none of them have developed evidence of chronic venous insufficiency. Follow-up cavagrams have been performed in a number of these patients and, in each instance, the cava was found to be patent and functioning normally. One patient died from massive cerebral hemorrhage one month following colon resection. At autopsy a large thrombus was trapped by the clip. The clip undoubtedly prevented this patient from having a pulmonary embolism.

Pulmonary embolism is frequently difficult to diagnose. At the present time we have four procedures that have helped make the problem of diagnosis less difficult. Determination of the LDH (with a normal SGOT), enzyme, lung scan, arterial oxygen tension and pulmonary angiography. Lung tissue contains large quantities of LDH and this enzyme is quickly released into the blood stream following pulmonary embolization. The LDH will be elevated in approximately 75 per cent of cases. Lung scans are extremely helpful and can be obtained at most hospitals. Following pulmonary embolization the arterial PO_2 usually falls to below 80 mm Hg. with the patient breathing room air. One can state that with a normal lung scan or a normal PO_2 , the diagnosis of pulmonary embolism must be questioned. On occasions one may need to resort to pulmonary angiography to establish the diagnosis.

The surgical residents have nicknamed the vena cava Big Blue and the abdominal aorta Big Red. At the present time we feel that prophylactic clipping

of the inferior vena cava should be considered an adjunct to many abdominal surgical procedures. The senior residents frequently remind the younger residents of this by telling them to "Think Blue" before closing the abdominal well. Presently we feel the admonition is justified.

Summary

Most surgeons have experienced the catastrophe of fatal pulmonary embolism following major abdominal surgery. The possibility that this complication can be avoided by prophylactically clipping the vena cava must be considered in all major abdominal surgical procedures in which the vena cava can be easily exposed. The procedure is simple, safe and effective.

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HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

March 10, 1973

Building Expansion: Received report on investigation of purchase of additional property.

Appointments: Beverly Sanders, M.D., Macon, to Committee on Legislation.

Committee Structure: Reversed a decision of February Executive Committee and re-established the Committee on Quackery as a separate committee.

Communications Committee: Received report from Chairman-Designate, Robert Wight, Tifton, on plans for new activities and expansion of ongoing efforts.

Regional Medical Program: Doctor Gordon Barrow

described the implementation of plans designed to gain Congressional extension and continuous adequate funding for RMP.

Professional Standards Review Organizations: Approved notification of Secretary of HEW, of MAG's desire for one state-wide PSRO area. Authorized Drs. Dowda and Buchanan to meet with HEW officials, if necessary, to achieve this objective.

Next Meeting: 9:00 a.m., Sunday, April 15, 1973, Conference Room, MAG Headquarters Building.

Contracting Cecal Lesion

W. C. LANG, JR., M.D. and GEORGE ATKINSON, M.D., *Atlanta**

DR. W. C. LANG: This is the case of a 42-year-old female being evaluated for chronic microcytic anemia. The patient was totally asymptomatic and denied any symptoms referable to the gastrointestinal tract. These are representative barium enema films. Dr. Atkinson, would you comment on these films?

Dr. George Atkinson: The barium enema films demonstrate an area of concentric narrowing of the cecum and a portion of the ascending colon (Figure 1). The terminal ileum appears to be free of involvement by this process. The appendix is filled and appears relatively uninvolved. The superior margin of the lesion is quite bothersome, in that it has what may be described as a "shelving" margin. As far as this patient is concerned, the important thing I think is to decide if this represents a malignant process or some form of inflammatory lesion.

Considerations

I would like to consider inflammatory lesions. Parasites, such as *endamoeba histolytica*, can involve the cecum with the superficial ulcerations and with secondary bacterial infection fibrous scarring can occur. The cecum could become contracted secondary to the scarring. The terminal ileum is not often involved and the appendix may also be uninvolved. These patients are usually quite symptomatic and also the clinician will be able to diagnose this condition by bacteriological study.

Tuberculosis is another consideration. Tuberculosis usually involves both the terminal ileum and the cecum. In this case, the terminal ileum is uninvolved. Patients with ileocecal tuberculosis almost always have evidence of pulmonary tuberculosis. There is no evidence that this patient has pulmonary tuberculosis. Right-sided diverticulitis may produce this appearance, however, there is no evidence of diverticula in the right colon and it is doubtful that this degree of scarring and contracture could occur as a result of diverticulitis.

Fungus diseases, such as actinomycosis should also be considered. Ulcerative colitis may involve the

right colon without evidence of left-sided involvement; this would be quite rare, however. Another form of colitis would be granulomatous colitis, this would be more likely to present with this appearance rather than ulcerative colitis. It would be helpful to see other segmental lesions, either in the distal colon or the ileum in establishing this diagnosis, however, no other areas are apparent.

In considering the possibility of a malignant lesion, a constricting "napkin-ring" lesion may present this appearance, particularly with the shelving margins superiorly. To have this much involvement of



FIGURE 1

Film of the right colon demonstrating contracting lesion involving the cecum. The appendix and terminal ileum appear relatively uninvolved.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

the lumen of the colon one would expect a very bulky lesion with displacement of the adjacent structures, such as the terminal ileum. There is no evidence that there is a significant mass in association with this constricting lesion. A scirrous type carcinoma would be infiltrated and possibly produce this appearance. These more commonly occur in the left colon. They are rare and occur most frequently in association with chronic ulcerative colitis. Considering all of the possibilities, I feel that this most likely is an inflammatory lesion, a segmental colitis seems the most likely.

Dr. Wade Shuford: What about the possibility of ischemic colitis?

Dr. Atkinson: I did not consider this possibility because of the rarity of the occurrence of ischemic lesions in the right colon.

Dr. Shuford: Do you think foreign body perforation could be a possibility?

Dr. Atkinson: This would also be a possibility with old perforation with scarring and granuloma formation.

Dr. Lang: The patient went to surgery with a pre-operative diagnosis of suspected carcinoma of the cecum. The patient underwent right colectomy. On gross and histological examination of the specimen the pathologist made a diagnosis of granulomatous colitis.

Comment

The accurate radiographic diagnosis of granulomatous colitis continues to be a significant problem, particularly when one attempts to differentiate it

from ulcerative colitis. In most instances, only the combined efforts of clinician, radiologist and pathologist can hope to make a large percentage of correct diagnoses.

From the radiographic standpoint the classic findings in granulomatous colitis have been carefully summarized by Margulis, et al.

The colon examination usually shows focal or segmental involvement (so-called "skip lesions") with the right colon most frequently involved. Also, the lesions have a tendency to be eccentric in location.

Ulcers demonstrated in granulomatous colitis tend to be deep (greater than 2 mm) and tend to be longitudinal, often creating a "cobblestone" effect. Deep fissures may be commonly seen perpendicular to the bowel lumen.

One of the most reliable findings is that of fistula and abscess formation, particularly in the region of a thickened ileocecal valve.

Stricture formation is not uncommon, although toxic megacolon is rarely seen. Generally, it is considered that the incidence of cancer is not increased in granulomatous colitis.

It is pointed out that these roentgen signs should be employed and applied as a set, and any single sign is less dependable.

Emory University School of Medicine 30322

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EMORY OFFERS PHYSICIAN'S ASSOCIATES FOR EMPLOYMENT IN 1974

Graduates of the Physician's Associate Program, Division of Allied Health Professions, Emory University School of Medicine will be available for employment in January, 1974. The program is of the Type A class as defined by the Board of Medicine of the National Academy of Sciences, has "preliminary approval" from the Division of Allied Health Professions, American Medical Association, and is approved by the Georgia Composite State Board of Medicine Examiners.

The program leading to an Associate in Medicine (or optional Bachelor of Medical Science) degree is 27 months in duration, consisting of five academic quarters and 12 months of clinical experience. During the clinical phase, students may concentrate in either family practice, internal medicine, or surgery (emphasis

on emergency care) after an initial core experience in surgery, internal medicine, pediatrics and gynecology-obstetrics.

Prospective graduates are encouraged to consider employment opportunities in medically underserved areas. Interested physicians are requested to write giving a brief description of the position available, the type of clinical experience preferred, i.e., family practice, internal medicine, or surgery, salary range, and other pertinent details. The program will provide a resume and evaluation of interested students to prospective employers on request.

For additional information and inquiries, please write Program Director, Physician Associate Program, Room 271, Woodruff Memorial Bldg., Emory University, Atlanta, Georgia 30322.

*A vasectomy clinic is described
which fulfills the qualifications
of the ideal sterilizing process.*

Characteristics of Vasectomy Patients Utilizing a Mobile Unit in Georgia

EDWIN S. BRONSTEIN, M.D. and DAVID LENTZ, B.S., *Augusta**

IN THE EXECUTIVE ORDER of July 19, 1971, Governor Jimmy Carter called for a comprehensive family planning program for all the people of Georgia. This program of comprehensive family planning includes sterilization as an alternative to temporary contraception. The Georgia sterilization law of 1970¹ permits all persons over 21[†] years of age and all married individuals with the spouse's permission to have a sterilizing operation. No longer need there be restrictions based on a magical number which is the product of the age and number of pregnancies of the couple. The growing popularity of vasectomy as an alternative for the couple who desire no more children is demonstrated by the increased utilization of a mobile unit for vasectomy in the Family Planning Project in Richmond County, Georgia. In the United States in 1970, there were an estimated 150,000 vasectomy operations performed; in 1971 there were 800,000 and probably one million or more were done in 1972.²

Tubal ligation of the female is the current preferred method of maintaining family size by sterilization in the United States.³ While recent developments in interval laparoscopic tubal ligation in both a hospital and an out-patient setting aim to reduce the operating time and the cost of female sterilization procedures, they cannot be equated at present with the ease, safety and low cost of vasectomy. As methods of female sterilization improve, couples will benefit by having a greater selection of alternatives available as a choice for permanent contraception.

Benefits of Vasectomy

The major consideration of an ideal sterilizing operation that are presently available by vasectomy are:

1. Low cost.
2. Short operating procedure.

3. Performed under local anesthesia.
4. Out-patient procedure.
5. Performed by family practitioner or specialist.
6. High success rate.
7. Rapid recovery time.
8. Minimal patient disability.
9. Ease of follow-up.

The use of the mobile unit in Richmond County has gained much popularity for vasectomy. It now provides services for patients from all over Georgia. The equipment fits in the Winnebago mobile family planning unit and can be carried to a site in Richmond or neighboring counties. At the present time, the vasectomy unit is housed in a second unit at a fixed site with the capability of going to other areas in the health district. By utilizing this mobile unit, more patients can receive the vasectomy operation in a smaller amount of time at a more reasonable cost.

Counseling First

The vasectomy program began in June of 1971. Each patient is counselled by a trained assistant to determine whether the sterilization procedure will promote the social, medical and emotional welfare of the family unit. The merits of sterilization for husband or wife are discussed and a decision is made. The applicant completes a detailed application and is told of the time and place of the operation and a description of all preparations for the operation. The operation and its effects are explained and the couple are told to regard it as an irreversible procedure.

A diagram explains the procedure and answers all questions regarding sexual activity and desire of the male. The importance of frequent sexual intercourse to remove the sperm beyond the site of operation is discussed and a complementary method of contraception is agreed on. It is emphasized that this method of contraception must be used until two negative sperm counts have been received. Though these were initially requested at eight and twelve

* From the Department of Obstetrics and Gynecology, Medical College of Georgia, and The Richmond County Health Department, Augusta.

Supported in part by: HSMHA Grant No. 04-H-000009-03-0, Maternal and Infant Care Project, Richmond County; HSMHA Grant No. 04-H-000331-02-0, Family Planning Project, Richmond County.

† On July 1, 1972, the age of majority became 18 years.

weeks post operatively, the patient was told that complete azospermia takes longer to achieve. The operation was regarded as complete when two seminal analyses showed azospermia at an interval of one month. However, the patient was asked to return in nine months after the operation to test for any re-anastomosis.

The surgical team in the mobile unit consists of a urology resident and a male nursing assistant. Three or four operations are performed at each clinic session. The cost per vasectomy in the mobile unit in the Richmond County Family Planning Vasectomy Project is \$59.49. This includes fees for the resident physician, for the nursing assistant, supplies, equipment and laboratory work for the patient's follow-up.

Patient Profile

The study sample consisted of 273 vasectomized patients from June 1, 1971 to June 1, 1972. The mean age of the husband was 33.70 years; the wife, 31.0 years and the mean number of children of this marriage was 2.3 (Table 1).

Twenty-eight and six-tenths per cent of the husbands and 29.7 per cent of the wives were in the age group, 30 to 34 years (Table 2). Of all vasectomy patients, 94.14 per cent were white and 2.20 per cent were non-white (Table 3); 73.25 per cent resided in Richmond County; 14.28 per cent were from Columbia County and 3.66 per cent were from Burke County; 22.40 per cent were employed in the U.S. Army; 15.52 per cent were blue collar and 15.52 per cent, white collar workers (Tables 4 and 5).

The typical vasectomized patient in the mobile unit is a 33.7-year-old white married Richmond County male whose wife was 31.0 years of age. He had 2.86 children and 2.30 children were from this marriage. His wife was not pregnant now and her last pregnancy was a normal delivery. His occupation was Army and his wife was not employed. He had no significant past illnesses before the vasectomy operation and no previous GU surgery. There was no history of diabetes, heart disease, or bleeding disorders, and he was not taking drugs now. He had

TABLE 1
CHARACTERISTICS OF 273 VASECTOMY
PATIENTS* BY MEAN, JUNE 1971-JUNE 1972

Age of husband in years	33.70
Age of wife in years	31.00
Number of children of husband	2.86
Number of children of marriage	2.30

* Performed in Mobile Unit of Family Planning Project.

TABLE 2
AGE OF COUPLE BY NUMBER AND PERCENT
WHO SELECTED VASECTOMY
JUNE 1971-JUNE 1972

Age (Yrs.)	Number	Percentage
Husband		
20	0	0
21-24	22	8.06
25-29	54	19.78
30-34	78	28.57
35-39	65	23.81
40-44	35	12.82
45 or over	16	5.86
Unknown	3	1.10
Total	273	100.00
Wife*		
20	2	0.91
21-24	22	10.05
25-29	62	28.31
30-34	65	29.68
35-39	37	16.89
40-44	12	5.48
45 or over	4	1.83
Unknown	15	6.85
Total	219	100.00

* First 54 patients did not provide this information.

TABLE 3
VASECTOMY PATIENTS BY RACE
JUNE 1971-JUNE 1972

Race	Number	Percentage
White	257	94.14
Non-white	6*	2.20
Unknown	10	3.66
Total	273	100.00

* Two Indians, four blacks.

TABLE 4
VASECTOMY PATIENTS BY PLACE
OF RESIDENCE
JUNE 1971-JUNE 1972

County	Number	Percentage
Burke	10	3.66
Columbia	39	14.28
Dekalb	1	0.37
Emanuel	1	0.37
Fulton	1	0.37
Jefferson	2	0.72
Jenkins	3	1.10
Hall	1	0.37
McDuffie	2	0.73
Richmond	200	73.25
Screven	1	0.37
Ware	1	0.37
Washington	1	0.37
Wilkes	1	0.37
Unknown	9	3.30
Total	273	100.00

VASECTOMY / Bronstein, Lentz

no allergies and had never been treated by a psychiatrist.

Data From India

Carlson⁴ in 1,241 vasectomy patients found a mean age of the husband of 35 years and the wife of 31.8 years. The average number of children of this marriage was 3.4; 99.9 per cent of the patients were white and 0.1 per cent non-white. Of 304 vasectomized patients in the Army of India,⁵ the largest group of patients (41.1 per cent) were also 30 to 34 years old. It is interesting to note that in the Indian Army no couples with less than two children volunteered for vasectomy; 6.2 per cent had two children; 31.2 per cent had three children and 33.2 per cent had four children. The average number of children per family was 4.11. Very few black males have accepted vasectomy in the studies of Carlson, Bronstein and Lentz.

What are some reasons for vasectomy? Of 304 respondents in the Indian Army, 37.8 per cent wanted to limit their family; 21.3 per cent already had an excessive number of children and 19.4 per cent had a satisfactory number of children. Jackson⁶ noted among 100 patients interviewed, 51.0 per cent of the families were large enough and 53.0 per cent found alternative methods unacceptable.

Of 304 vasectomy respondents in the Indian Army, 18 per cent noted immediate disagreeable side effects; 87 per cent noted no change in their sex lives; 13 per cent had enhanced sexual desire and 10 per cent reported a weakened sex desire.⁷ The number of cases showing sexual disharmony after the vasectomy operation increased with the de-

cline in the social class. Simon Population Trust, a vasectomy clinic in Cambridge, England, reported 1,012 vasectomized men in their clinic.⁸ Of the group, only five couples experienced a change for the worse in their sex lives. Seventy-five per cent of the respondents were more satisfied with their sex lives and 70 per cent experienced greater sexual desire. Varma⁹ noted that three of 73 vasectomized males felt less satisfied with their sex lives and 70 per cent experienced greater sexual desire. Each had a pre-existing potency difficulty that was aggravated after the operation. If a man submits to a vasectomy when he is burdened with self doubts, immaturity and a host of sexual hangups and if he is in search of a magical solution to his real or imagined ills, he is probably making a mistake by being vasectomized. Jackson¹⁰ estimates that only 3 per cent of all vasectomized men would not go through with it again, given the chance to do it over.

Few Complications

Complications are very uncommon among vasectomy patients. Alderman¹¹ noted among 1,923 vasectomy patients, two hematomas and three scrotal abscesses. There were 19 failures (0.98 per cent). Removing six of the failures from an experimental series, the failure rate dropped to 0.68 per cent. Among the 273 vasectomized patients at the Richmond County Clinic, no pregnancies among the wives have been reported. Six patients have had follow-up sperm counts which remain positive (2.20 per cent). Five of these patients have had a repeat operation with three negative sperm counts and two awaiting results. One patient has refused the second operation. To date, 72.77 man years of permanent contraception have been achieved.

Sterilization is proscribed for orthodox Jews, Muslims, and Roman Catholics. Among 330 couples who chose vasectomy, 19 per cent of the men and 24 per cent of the wives were Catholic.¹² Of the Catholic men, 52 per cent reported increase in sexual desire, in contrast to 35 per cent of the Protestant men reporting.

Summary

Vasectomy is an important alternative to the couple for permanent contraception. The ease of operation, low cost, low morbidity and high success make vasectomy a more desirable procedure for men throughout the United States. Each year more vasectomies are being performed. A mobile clinic within the framework of a family planning project has been described and the characteristics of 273 patients have been reported on during the first year of operation. Six patients have had follow-up sperm

TABLE 5
OCCUPATION OF VASECTOMY PATIENTS BY
NUMBER AND PERCENTAGE
JUNE 1971-JUNE 1972

Occupation	Number	Percentage
Army	49	22.40
Blue collar ¹	34	15.52
White collar ²	34	15.52
Salesman	13	5.94
Student	2	0.91
Unemployed	5	2.27
Unknown	82	37.44
Total ³	219	100.00

1. Blue collar includes painters, truck drivers, carpenters, mechanics, pipe fitters, machinists.

2. White collar includes deputy sheriffs, supervisors, LPN's laundry managers, photographers, music directors.

3. First 54 patients have no recorded information.

counts which remain positive (2.20 per cent). Five of these patients have had a repeat operation with three patients having two negative sperm counts and two not complete. Vasectomy is an excellent alternative for the couple seeking permanent contraception. Each year more and more couples are selecting this method. At the present time, the black male has not accepted this method.

Acknowledgement

I wish to gratefully acknowledge the work of Dr. Daniel H. G. Glover, Mr. John C. McCaskill, Miss Vera Greeson of the Richmond County Health Department and the residents of the Department of Urology at the Medical College of Georgia.

Medical College of Georgia 30902

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**MEDICAL AID STATION WINS FRIENDS AMONG
AILING LEGISLATORS**

As simple as aspirin or sophisticated as an EKG machine, medical attention and supplies were available instantly to legislators again during the 1973 General Assembly, a courtesy of the Medical Association of Georgia.

The well-received Doctor-of-the-Day program and medical aid station are housed in a room provided by the State across from the House galleries on the fourth floor. Each day a MAG volunteer physician and a nurse provided by an area hospital staffed the station from the time the legislature convened at 9 a.m. until the day's committee hearings and meetings were over.

Doctors-of-the-Day in 1973 came from Brooklet and Commerce, Toccoa and LaGrange—in fact, 80 per cent made the trip for a day's service from outside the Atlanta area. This year a special effort was made to recruit the personal physicians of the legislators for the program and many other volunteers considered it a personal courtesy to their local delegation.

Though each day of the session would bring an average of 25 visits from legislators and their staffs, "fortunately, there has been nothing critical" in the way of health problems this year, volunteer Jack M. Waldrep, M.D. of Rome reported during the last week of the session. However, his first tour as Doctor-of-the-Day in 1972 brought a legislator to him with emergency heart problems.

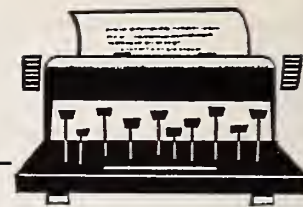
Colds, headaches and indigestion are the usual complaints, and a file cabinet of medications, "a miniature drug store," can provide whatever relief is necessary. Dr. Waldrep said that these complaints are natural for the lifestyle into which the legislators are suddenly thrust. "Their habits are not regular and they really burn the candle at both ends."

In addition to its supply of medications, the station

contains an examining table, EKG machine and data-phone connected with the office of James A. Kauffman, M.D. in Atlanta, who, with Charles Watkins, M.D. of Chamblee, is co-chairman of the program, and can arrange for additional medical aid if needed. As an extra service during the session, legislators could take advantage of the influenza vaccine and electrocardiogram that were offered.



Health care attention was available daily to legislators and their staffs from volunteer Doctors-of-the-Day such as Jack M. Waldrep (L) of Rome, aided by Mrs. Jean Owens, R.N. of Georgia Baptist Hospital in Atlanta.



Summary of Medical Legislation 1973 Georgia General Assembly

The following is a summary of some of the legislation of interest to the Medical Association of Georgia that was considered during the 1973 session of the General Assembly.

CHIROPRACTIC INSURANCE COVERAGE (H.B. 147)—This bill titled “Freedom of Choice” would require all health and accident insurance policies to reimburse chiropractors for their services. Under this bill the insurance companies would be forced to include chiropractic services in every health policy sold. The insured would therefore be forced to purchase this coverage whether or not he wanted it. The results of this legislation would be two-fold: The premiums on all health and accident policies would go up; and chiropractors would be labeled physicians in all health and accident policies. H.B. 147 received an adverse recommendation by the House Insurance Committee. The chiropractors, discouraged by the defeat of this bill in Committee, will push even harder in 1974 to try to enact the same type legislation.

CHIROPRACTIC MEDICAID (H.B. 858)—House Bill 858 would expand the word “physician” under Medicaid to include chiropractic services whether furnished in the office, the patient’s home, the hospital, a nursing home or elsewhere. Legislation of this type would unquestionably increase Medicaid payments, and in a short time probably force Medicaid into bankruptcy. The House Human Relations Committee will study this bill during the interim between the 1973-1974 legislative session. Medicine will definitely have to contend with H.B. 858 during the ’74 General Assembly.

ABORTION (H.B. 915)—This bill, as originally introduced, did not include what MAG desired in abortion legislation. The original bill passed the House of Representatives and went to the Senate. MAG had a substitute bill drawn and introduced in the Senate Health and Welfare Committee. This substitute bill passed the Senate and the House of Representatives, and upon the Governor’s signature will become law. Simply stated, this bill requires that all abortions be performed by duly licensed physicians and that after the first tri-mester abortions must be performed in a licensed hospital or facility licensed by the Georgia Department of Human Resources. After the second tri-mester the physician and two consulting physicians must certify that said abortion is necessary in their best clinical judgment to preserve the life and health of the woman. In addition, any person who shall state in writing objections to any abortion or all abortions on moral or religious grounds shall not be required to participate in the procedures if it will result in such abortion. A copy of this Legislation is available upon request through MAG Headquarters.

CERTIFICATE OF NEED (H.B. 504)—This bill would require anyone who wishes to build or substantially enlarge a hospital or nursing home to obtain a certificate of need from the State before construction begins. As presently written MAG opposes such Certificate of Need Legislation and helped to defeat H.B. 504 in the Senate Health & Welfare Committee where it will be studied during the interim. If H.B. 504 could be altered to such a degree that all physicians would not be as drastically affected, MAG would support such legislation. However, at

present, MAG is in opposition to the Hospital Association, the Nursing Home Association, the Department of Human Resources and the Governor on this type legislation.

HEALTH-WELFARE BOARDS MERGER (H.B. 360)—This bill, originally designed to merge all county health and welfare boards into a single county level Human Resources Board, passed the House but was put into an interim study committee (EREG—Economy, Reorganization and Efficiency in Government) in the Senate. It remains a live bill and could be acted on during the '74 session of the Legislature.

BOARD OF DENTAL AND MEDICAL EXAMINERS (H.B. 92)—This bill passed both the House and the Senate and will become law upon signature of the Governor. H.B. 92 will raise the current per diem allowances of \$25 a day plus mileage and expenses for the members of the Dental and Medical Boards of Examiners to include payment of \$1,500 per examination. Although this bill only affects 12 to 18 MAG members, MAG helped in its passage.

DRIVERS LICENSE ADVISORY BOARD (H.B. 21)—This bill creates an advisory board to set up and review standards of physical and mental capabilities that enable persons to operate a motor vehicle safely. This board would be made up of physicians dealing with eye diseases, other physicians and optometrists. This bill passed both the House and Senate and will become law upon the Governor's signature. A similar law handed down nationally had to pass the Georgia General Assembly this year in order for the Department of Public Safety to receive 10 per cent of its funds from the Federal Government. MAG did not approve the wording of H.B. 21 nor the proposed composition of this board, but due to the national model it was impossible to defeat H.B. 21 on those points.

ALIEN RECIPROCITY (H.B. 650)—This bill says that any alien licensed in another state with which Georgia has reciprocity can receive a Georgia license without taking another examination if the reciprocal state has *equal* or *higher* requirements for medical licensure. This bill will become law upon signature of the Governor.

HYPNOTISM (H.B. 370)—H.B. 370 would prohibit the use of hypnotism except by physicians, dentists and licensed psychologists. It will take hypnotism off the stage and put it solely in the hands of professionals who know the implications and effects of hypnotism. This bill passed the House of Representatives and was placed in an interim study committee by the Senate Institutions and Mental Health Committee. MAG endorses this bill and tried unsuccessfully to get the Chairman of the Senate Institutions and Mental Health Committee to favorably pass it to the General Senate for vote. H.B. 370 will still have a chance in 1974 session.

MEDICAL PRACTICE ACT (S.B. 387)—This bill sponsored by MAG would define the term "Doctors of Medicine," "Licensed Doctors of Medicine," "Doctors of Medicine Licensed to Practice in the State" and similar terms as meaning and including only those persons who have graduated from a medical college and hold the degree of Doctor of Medicine and who are also licensed to practice medicine under Chapter 84-9. The reason for S.B. 387 is to tighten the Medical Practice Act as to who a Doctor of Medicine is and who shall use an M.D. behind their name. This bill passed both the House and the Senate and will become law upon the Governor's signature.

PROFESSIONAL HEALING ARTS LICENSURE—ACCREDITATION (H.B. 699)—MAG sponsors this legislation which would require any applicant for a license to practice medicine, dentistry, osteopathy, podiatry, optometry or chiropractic in this state be a graduate of a school or college that is accredited by an accrediting agency that is recognized and approved by the National Commission on Accrediting or the Office of Education, U.S. Department of Health, Education and Welfare. This bill in no way will affect anyone presently licensed and practicing in Georgia. H.B. 699 has an effective date of 1979 to give the chiropractic schools (the only profession that is not accredited by either of these

organizations) ample time to upgrade the caliber of their schools to become accredited—and through their own publication they have stated this would be impossible. H.B. 699 passed the House Health and Ecology Committee and is now in the House Rules Committee. After deliberations between MAG and various representatives it was decided to leave H.B. 699 in the Rules Committee this year. The first day of the 1974 session H.B. 699 will go back to the Health and Ecology Committee and be reintroduced for the 1974 session.

This additional time would be well used if all physicians and interested parties in Georgia contacted their representatives and senators during the next nine months to encourage their support for this legislation which will upgrade the health care available to every citizen in Georgia.

Thank You

Due to the efforts of many MAG members the 1973 session was extremely favorable. I personally want to thank you for the time, money, and effort each of you put forth this year. It was extremely helpful and the results are obvious. All Legislation that was not defeated this year or remains in a study committee is still a live piece of legislation and will be considered again next year.

During the summer months it is extremely important that you contact your representatives and senators informing them of your wishes and desires concerning the passage or defeat of specific legislation. If you need any additional information or would like a copy of any legislation please contact MAG Headquarters, 938 Peachtree St., N.E., Atlanta, Georgia 30309.

*Rusty Kidd
Legislative Representative*

COORDINATED EFFORTS MEANT SUCCESS IN THE 1973 GENERAL ASSEMBLY

Motivated by a desire to bring good health care legislation to the citizens of the state, the Medical Association of Georgia makes a commitment of time and money each year in a concerted legislative effort.

Though the day to day contact with legislators at the Capitol is essential, the foundation for a successful MAG year is laid by physicians working in each city, each district. Because of their efforts, members of the General Assembly are aware of the interest in health care legislation back home and respond well when MAG approaches them to explain our position.

The coordinating body for this state-wide effort is the MAG Legislative Committee whose chairman for the state legislature is Harrison L. Rogers, Jr., M.D. of Atlanta. Working closely with the Committee on Quackery, whose chairman is James A. Kaufmann, M.D. of Atlanta, the committee anticipated the session by reviewing bills considered last year, deciding what legislation MAG might want to sponsor this year and planning the means for promoting acceptance of our opinions.

Implementation of the plans was the responsibility of a core staff headed by Rusty Kidd who joined MAG



Legislative representative Rusty Kidd takes advantage of the House noon recess to discuss MAG's point of view with Harry Dixon (D-Waycross) and Tom Carr (D-Sandersville).



**Who
killed
the
wicked
itch**

(and the infection)*

?

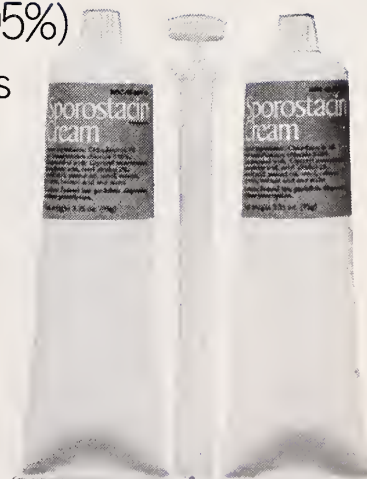
snow white
Sporostacin Cream

TRADEMARK

(chlordantoin 1% and benzalkonium chloride 0.05%)

After you write your prescription for two tubes of soothing, fungicidal Sporostacin Cream, tell your patient not to be fooled by the quick relief of symptoms it affords. Make sure she knows how to use it as directed—for the *full* 14-day course of therapy. Then, on follow-up, you'll usually find that nonstaining, easy-to-use Sporostacin Cream has finished off vulvovaginal candidiasis in the nicest possible way.

two tubes...two weeks



*

Indication: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

"Probably" effective: For the treatment of vulvovaginal candidiasis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: None known. **Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued. **Dosage:** One applicatorful intravaginally twice daily for a period of 14 days. Course of therapy may be repeated if necessary.

Ortho Pharmaceutical Corporation • Raritan, New Jersey 08869



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EFFORTS / Continued

as legislative representative in November, 1972. He was aided at the Capitol by field representatives Wallie Carpenter and Carl Bailey who were available to make personal contacts, phone calls, sit in on the proceedings of the House or Senate and attend committee meetings when more than one involved with health care legislation were scheduled at the same time.

A quick glance over the make-up of the 1973 General Assembly showed them that it would be an unpredictable one: 11 out of 56 senators and 40 out of 180 representatives were freshmen. To establish good relationships with the new legislators and deepen ties with the veterans, a key physician program was begun. The personal physician of each legislator, or another MAG member who could establish a strong tie with each legislator was recruited.

The first of a series of Bulletins on Health and Medical Legislation went to these key contact physicians giving them advice on carrying out their responsibilities effectively. Study the issues thoroughly, they were told. Allow plenty of time for your approach with the legislator and don't "over contact" him. Yet let him know that you are always available to advise him, you appreciate his consideration and can help get support from your fellow physicians and voters.

Four of the 11 issues of the bulletin went to the entire MAG membership, and all served as weekly updates on the progress of bills as they were introduced, assigned to committee, debated and voted upon. They gave the names and addresses of members of committees considering health care bills, offered sample letters to use when contacting them, and gave day and evening phone numbers where MAG staff members could be reached for information and help.

Though the key contact physicians had special responsibilities, all members were urged to "wire . . . call . . . write!" their legislators regularly throughout the session and to enlist their friends and relatives in the project. A great deal of interest and involvement was shown on the part of auxiliary members who frequently had more time than their husbands to make contacts and write letters.

Some county medical societies put forth special effort. Dougherty County, for example, ran a quarter page advertisement in the *Albany Herald* headlined "Insurance Freedom." It listed the reasons for their objections to House Bill 147, "Freedom of Choice Chiropractor's



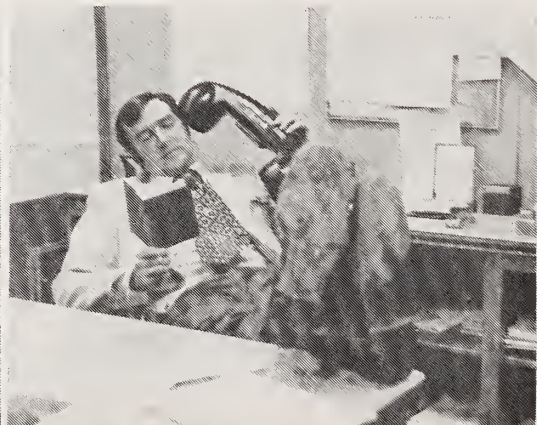
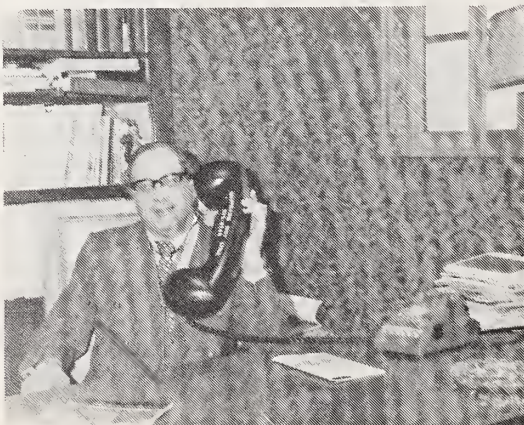
Many MAG and WAMAG groups made a special trip to tour the Capitol during the 1973 session, and introduced themselves to their legislators. Included here are: (first row, L-R) Mrs. J. Hagan Baskin, Jr., Decatur, President of MAA's auxiliary; Mrs. Cliff Moore, Rome, president WAMAG; Mrs. Howard S. Brown, Dunwoody, WA-SAMA liaison; Miss Ruth Moore, Rome; Marcella Woods, M.D., Atlanta; (second row, L-R) Mrs. Perry M. White, Atlanta, state legislative chairman for WAMAG; Mrs. John Bates, Cuthbert, president-elect WAMAG; Lt. Gov. Lester Maddox; Mrs. Stanley Gregoroff, Atlanta, MAA auxiliary legislative chairman.

Bill," and asked the public to let their legislators hear from them to defeat the measure.

During the two and a half month session, some MAG members were called upon to testify at committee hearings. Many others, including auxiliary members, visited the Capitol. While there they helped the cause by calling their legislators from the chambers, introducing themselves as affiliated with MAG, and expressing their interest in the activities of their state government.

Another way legislators realize the political impact of physicians has been through GaMPAC, Georgia Medical Political Action Committee to which approximately a third of the MAG membership and their wives belong. Legislators who have received contributions during their campaigns were willing to sit and listen to MAG's opinion on critical bills.

The make-up of the General Assembly will remain the same for the 1974 session as no elections are held this year. The spring, summer and fall months should be used for continued contacts with your local delegation to show that MAG's interest in good government and good health care for Georgians does not disappear after the adjournment of the Assembly.



Ups and downs in the fortunes of MAG legislation meant frequent telephone calls for advice and consultation between Legislative Committee member James Kauffman, M.D. of Atlanta, who takes a special interest in the effort each year, and Mr. Kidd. Note the "Kauffman Hot Line."



THE CLINICAL IMPORTANCE OF THE TRIFASCICULAR CONDUCTION CONCEPT

STUART J. TOPOROFF, M.D., *Atlanta*

SEVERAL YEARS AGO the electrocardiographic diagnosis of heart block was relatively simple. First, second and third degree heart block coexisted with right and left bundle branch block. Recently, Rosenbaum published several articles introducing the concept of trifascicular conduction and a new term that seems destined to last, namely, hemiblock. Knowledge of the trifascicular conduction system anatomy, blood supply, current nomenclature and electrocardiographic diagnosis is of importance in several acute and chronic clinical situations and is the purpose of this discussion.

Electrical impulses reaching the A-V node are propagated down a path leading to the bundle of His. The His bundle, located in the membranous ventricular septum, bifurcates into the right and left bundle branches. The right bundle branch is a long, discrete, relatively vulnerable group of fibers continuing to the apex of the right ventricle before communicating with the Purkinje system and initiating right ventricular depolarization. The left bundle branch is a thick, short group of fibers which, after descending through the ventricular system, splits into two fascicles or divisions; an anterior-superior division which travels through the subendocardium of the anteriolateral wall of the left ventricle terminating in the anterior papillary muscle where it intermingles with the Purkinje system, and a posterior-inferior division which runs through the subendocardium of the inferior wall of the left ventricle meshing with the Purkinje system in the posterior papillary muscle. The Purkinje system, then, is capable of activation via signals from three separate sources, the right bundle and the two fascicles or divisions of the left bundle, hence the description trifascicular. Interruption, or block, may occur separately at any of the three levels, or in combination. Since the distal right bundle and anterior-superior division of the left bundle have a close anatomical relationship within the ventricular septum, and a common blood supply from septal branches of the anterior descending coronary artery, simultaneous block of these two fascicles occurs commonly.

Nomenclature Confuses

Nomenclature in trifascicular conduction is a significant cause of confusion. Block in the anterior-superior division of the left bundle results in left axis deviation exceeding 30° in the frontal plane (limb leads) of the scalar electrocardiogram. Most left axis deviation tracings are, in reality, caused by block of the anterior-superior division. This is called left anterior divisional (fascicular) block or, as there are two "halves" to the left bundle, left anterior hemiblock. Left ventricular parietal block or arborization block were previously employed terms for left frontal axis deviation.

If left anterior hemiblock occurs concomitantly with an acute septal infarction with injury to the anterior division within the septum, or an acute anterolateral infarction with injury to the anterior division peripherally within the subendocardium of the anterolateral wall, the term anterior peri-infarction block may be used. This

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

has no special clinical significance, although its understanding illuminates the relationship between the conduction system and its blood supply. The posterior-inferior division of the left bundle is a shorter, less vulnerable, thicker group of fibers than the anterior division. Branches derived from the right coronary artery usually compose its blood supply. There is little anatomical proximity between the posterior division of the left bundle and the other two fascicles, accounting for the paucity of combined block involving the posterior division. If, however, combined block does occur in the right bundle and the posterior division of the left bundle due to coronary artery disease, involvement of their separate coronary artery sources implies a diffuse multi-vessel coronary artery process. Existing conduction is then supplied by the anterior division of the left bundle with its impaired blood supply. The integrity of the conduction system is severely threatened, and indeed, complete heart block occurs in a majority of cases with this electrocardiographic pattern. A second explanation for the rarity of coexisting right bundle branch block with left posterior hemiblock is that coronary artery disease of a magnitude to cause their dual involvement may not leave sufficient viable myocardium to sustain life.

Posterior-inferior divisional (fascicular) block, or left posterior hemiblock, is an uncommon and imprecise electrocardiographic finding. The posterior fascicle, being shorter and thicker than the anterior fascicle, is not vulnerable to isolated insults. Block of the posterior division causes a vertical axis in the limb leads of the scalar electrocardiogram. This pattern may be found with right ventricular hypertrophy, chronic pulmonary disease, or young slender normal patients. The diagnosis should not be made without comparative tracings or specific clinical information.

If posterior hemiblock occurs concomitantly with an acute inferior infarction with injury to the posterior division proximally or peripherally within the subendocardium of the diaphragmatic wall, posterior peri-infarction block is said to occur. As with anterior peri-infarction block, this has little clinical significance except as an aid to overall understanding.

Trifascicular Nature

There are specific clinical settings where understanding of the trifascicular nature of the conduction system is important. Friedberg observed that 59 per cent of patients presenting with complete heart block exhibited prior electrocardiographic tracings of combined right bundle branch block and left anterior hemiblock (incomplete bilateral bundle branch block). Conduction through the remaining fascicle of the left bundle, the posterior division, may be intermittent, resulting in transient symptoms (dizziness, syncope, seizures), due to complete heart block. These patients may be improved by pacemaker implantation before permanent heart block develops, if the electrocardiographic pattern is recognized.

Several reports have been published advocating prophylactic, temporary pacemaker insertions in CCU patients developing right bundle branch block with left anterior hemiblock, citing a significant incidence of fatal complete heart block without electrical pacing.

Another recent study revealed that CCU patients with right bundle branch block, left anterior hemiblock, and transient complete heart block requiring temporary pacing had a significantly increased rate of sudden death after pacemaker removal, compared to a similar group who had permanent pacemakers implanted prophylactically despite the transient nature of their complete heart block.

Right bundle branch block is more frequent, and often found in patients without overt clinical heart disease compared to left bundle branch block, because the right bundle is more vulnerable to small, isolated insults.

Conduction system defects are due to coronary artery disease in the majority of cases, but Lenegre's disease (idiopathic degeneration of the conducting system leading to fibrosis) or Lev's disease (intracardiac sclerosis) must be invoked in patients in whom no etiology can be ascertained.

In patients with incomplete bilateral bundle branch block and transient symptomatology, bundle of His studies and Holter monitoring have proven useful in assessing conduction through the remaining fascicle.

*Division of Cardiac Services
St. Joseph's Infirmary
265 Ivy Street 30303*

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NEWS SPOT PROGRAM CARRIES HEALTH CARE LEGISLATION INFORMATION TO VIEWERS ACROSS THE STATE

As a 12-year-old page hurried into the adjacent House chambers to deliver a message, the drone of the proceedings escaped for a moment into the brightly lit lobby where a South Georgia representative was explaining before the camera his objections to the chiropractic insurance bill. His two-minute interview, and several others taped earlier in the day, would be rushed to processing, then mailed to target stations across the state for airing on their news programs.

A similar scene was repeated each Wednesday during the 1973 Georgia General Assembly. Since logistical and manpower difficulties preclude most stations outside the Atlanta area from giving the activities of the session wide coverage, and health care legislation goes virtually unnoticed, the Medical Association of Georgia was seeing that whatever the issue—chiropractic, hypnotism, certificate of need—there could be coverage on this influential medium.

The legislative news spot program was initiated as a project of MAG this year in the hope that it would give us "the opportunity to get closer to several of the legislators as well as present our case in the court of public opinion," explains Charlie Templeton, MAG's director of public and professional relations.

Target cities and stations for the project were: Macon (WCWB), Columbus (WRBL), Savannah (WSAV), Augusta (WJBF) and Albany (WALB). Preliminary work included approaching these stations with the idea to determine its potential acceptance. The initial reaction was good . . . naturally, since the stations were offered free news coverage from the Capitol that involved unbiased interviews with their own local senators and representatives. In return, MAG asked that they make the news clips an integral part of their programs and that they send a reply card each week noting usage.

Legislators in the stations' broadcasting area were contacted individually by Rusty Kidd, legislative representative for MAG, and personally invited to participate. The persuasive thrust of the offer was that they would be providing the citizens of Georgia with health care legislation information as well as getting a legitimate publicity outlet with their local television stations.

Each week the set of legislators to be interviewed was informed of the subject, provided with background information that included MAG's position on the bill and any other supportive data that would as-

sist them in deciding what they would say. In this way the project insured that participating legislators would keep up with health care legislation and would be aware of MAG's position. Taping, with the aid of an independent news man and cameraman, took several hours on Wednesday, and by Thursday the film was on its way to the five cities.

MAG was happy, the legislators were happy . . . and the television stations were happy, as reflected in the following letter from Jim Davis, news director of WALB-TV in Albany:

"We very much appreciate the film interview with Representative Billy Lee concerning the bill on hypnotism. The quality and content were excellent.

"I sincerely hope that you will be able to expand and extend this service in the next session. Let me assure you that all the material you send, as long as it is of this type and quality, will be used on WALB-TV news. . . ."



North lobby of the House chambers provides a taping area for the news spot program directed by Charlie Templeton (L), MAG director of public and professional relations, and Jim Whipkey, seasoned Capitol correspondent who served as the independent interviewer.



MEDICAL RECORDS: AN ATTORNEY'S VIEW

DARYLL LOVE *and* STUART E. EIZENSTAT, *Atlanta**

MEDICAL RECORDS are all those papers, documents, photographs, x-rays and other tangible things which relate to the care and treatment of individuals by physicians and medical institutions. Medical records also include bills and charges for services rendered and for hospital, medical, medicine and drug charges. The term is broad enough to include motion pictures taken during a patient's surgical or operative procedure.¹

Attorneys realize that physicians rely heavily upon their notes, office records, etc. to refresh their recollection of a patient's care and treatment many years later. Hospital staff and nurses seldom recall what treatment or medicines were administered without reference to hospital records and few, if any, physicians would perform extensive medical or surgical procedures without a thorough review of the patient's medical history.

Medical records are also important directional tools in an attorney's prosecution or defense of a personal injury claim. Through the use of the plaintiff-patient's medical records, the attorneys can define the parameters of liability and injury and demonstrate the nature and extent of previous injuries which may increase or decrease the value of the claim. Once a lawsuit is filed by the plaintiff-patient seeking damages for his injuries, medical records maintained by a medical institution or by a physician are discoverable and are not privileged. The records may be obtained by subpoena or by taking the deposition testimony of the custodian, including the treating physician, with a subpoena served requiring the witness to produce his records at that time.

Data for Support

All this is generally known to physicians and people working in the medical sciences. But what do attorneys look for in medical records and how do they intend to use what they find in the development, prosecution and trial of a lawsuit? This may be demonstrated by using an example showing the attorney's purpose and technique: A patient has been involved in an automobile accident and complains to his physician of neck and back pain. Sometime later, the patient-plaintiff files a lawsuit claiming that the defendant's negligent act caused the collision and his injuries, damages, etc. Either before or shortly after the filing of the lawsuit, the plaintiff's attorney has studied his client's medical records and has often conferred with his physician. The defense attorney will require the production for inspection of all medical records (some physicians believe from the beginning of time) in order to determine the objective data supporting the plaintiff's claim. The defense attorney is looking for all those entries reflecting the history of the incident given to the physician by the plaintiff, e.g. how the incident occurred, etc. and the nature and extent of any previous injuries. What the plaintiff tells his physician at this first examination following the collision is generally reliable assuming that the plaintiff

* Prepared at the request of the Medical Association of Georgia. Mr. Love and Mr. Eizenstat are associates in the firm of Powell, Goldstein, Frazer & Murphy.

is concerned more with recovering from his injuries than recovery of money damages. If, at trial, the plaintiff offers testimony inconsistent with the history he gave to his physician, the physician's testimony describing that history may be used to impeach or attack the plaintiff's credibility.²

Admissible Records

A distinction should be made between the medical records maintained by a medical institution and those records maintained by a physician. Copies of hospital records when properly certified by a medical records librarian or custodian of hospital records, may be introduced as authentic and admitted in evidence at trial.³ On the other hand, medical records maintained by physicians are not admissible unless: they are writings made as memoranda in the regular course of business if it was the regular course of the physician to make such memoranda at the time of the act, transaction, occurrence or event or within a reasonable time thereafter.⁴ If such a showing is made, the physician's records, or true and correct copies of those records, are admissible at trial even though the entrant or maker (secretary) lacks personal knowledge of the act, transaction, etc.⁵

To say that copies of medical records are admissible at trial does not mean that all entries in those records are admissible before the Court and jury. Often, and nearly always, the records contain "hearsay" which is testimony in court or written evidence, or a statement out-of-court, with such statement offered as an assertion to show the truth of the matters asserted therein, and resting for its value upon the credibility of an out-of-court asserter.⁶ As an example, medical records, and especially emergency room reports, usually contain a statement by the patient as to how he sustained his injuries and often contain the physician's initial diagnosis and prognosis. If these entries are not challenged at the time the medical records are tendered as evidence, the opposing party may not have the opportunity to cross-examine the "out-of-court asserter" or witness concerning his conclusions, diagnosis, prognosis, causal relationship between the incident and the plaintiff's injuries, etc.⁷ Georgia law places strict evidential standards to admit a physician's testimony of his care and treatment and his "opinion" as to the competent producing cause of his patient's injuries. Where the physician's opinion is based in material part on the history as given to him by his patient, his opinion of causation based on that history may not be admissible at trial.⁸

Under Georgia law, the plaintiff is competent to identify doctors' bills, hospital bills, ambulance service bills, drug bills and similar bills incurred in connection with the treatment of his injuries and he has the duty to segregate or eliminate expenses not incurred in the treatment of the injury which is the subject of the lawsuit.⁹

In conclusion, medical records are the initial sword and shield of the opposing parties in a personal injury lawsuit. Complete and legible medical records are important if not crucial to the patient, his physician and to allow for the proper evaluation of the plaintiff's claims by his attorney, the defense attorney, the court and jury.

Eleventh Floor

C&S National Bank Building 30303

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SOCIETIES

Heading up a new slate of officers for the **DeKalb County Medical Society** for 1973 is John P. Heard. Assisting him will be Benjamin B. Okel, president-elect; Lawrence L. Freeman, vice-president; O. Wytch Stubbs, Jr., secretary; and Philip M. Jardina, corresponding secretary.

PERSONALS

Fifth District

Three Atlanta physicians received the Award of Honor of Emory University Medical Alumni Association at a March 6 annual dinner-dance. Recipients were **J. Willis Hurst**, professor and chairman, Department of Medicine, Emory University School of Medicine; **A. Hamblin Letton**, president of the Atlanta Medical Center and chief of staff and attending surgeon at Georgia Baptist Hospital; and Carter Smith, Sr., former president of both the Emory Medical Alumni Association and the Alumni Association of Emory University.

Bernard S. Lipman, Atlanta, was guest speaker for the February annual Heart Meeting of the Buchanan County Medical Society, St. Joseph, Mo. His presentation was titled, "Controversies in the Management of Heart Attacks—1973."

E. Napier Burson, Atlanta, has been awarded the 1972 Aven Cup given each year since 1954 by the Medical Association of Atlanta to a physician for outstanding citizenship. Dr. Burson was cited for his long-time leadership in the health planning activities of the Community Council of the Atlanta Area, Inc. which included developing an information and referral system for the area's health and social agencies.

Sixth District

Claude L. Pennington, Macon, has been elected president of the American Council of Otolaryngology, a medical society representing the nation's 7,500 ear, nose and throat specialists and their patients. He has

served the Council two years as vice president of the board and executive committee member. Dr. Pennington is immediate past chairman, Department of Otolaryngology, Medical Center of Central Georgia in Macon where he now serves on the senior attending staff.

James W. Pilcher of Louisville has been named to the medical advisory staff of Extendicare, Inc., the company that operates Jefferson Hospital in that Georgia city. Dr. Pilcher is a general surgeon who was graduated from the Medical College of Georgia.

Seventh District

Douglas resident **William R. Wills** has been elected president of the staff of Coffee General Hospital for 1973. He is a graduate of Mercer University and Medical College of Georgia.

Tenth District

Orthopedic surgeon **Joe D. Christian, Jr.** of Augusta was recently elected to membership in the American Society for Surgery of the Hand at its 28th annual meeting in Las Vegas, Nev.

DEATHS

Alfred Mann Battey, Jr.

Augusta surgeon Alfred Mann Battey, Jr. died following a heart attack January 18, 1972, the eve of his 52nd birthday.

Member of a noted Augusta medical family, Dr. Battey was related to Dr. Louis Alexander Dugas, a founder of the Medical College of Georgia and member of the clinical faculty of the school. His grandfather was Dr. William Whatley Battey, and his uncle, with whom he began practice, was Dr. William Whatley Battey, Jr.

His degrees came from the University of Georgia and the Medical College of Georgia (1944). He served as a medical officer in surgery on a troop ship while a captain in the Army Medical Corps.

Residency in general surgery was served at the University Hospital in Augusta. Dr. Battey was a Fellow in the American College of Surgeons, member of the Richmond County and American medical societies, a director of the Citizens and Southern National Bank and member of St. Mary's on the Hill Catholic Church.

Survivors include his widow, Mrs. Bertha Battey; daughters, Mrs. Therese Battey Evans, Bertha Lee Battey, Grace Dugas Battey, Elizabeth Barrett Battey and Caroline Tennent Battey; sons, Alfred Mann Battey, III and Thomas Barrett Battey; brother, Dr. Louis L. Battey; sister, Mrs. Robert G. Davis of England; and mother, Mrs. Fannie Dugas Battey.

Robert Allen Clark, Jr.

Robert Allen Clark, Jr., Macon neurosurgeon, died March 6 at the age of 49.

Dr. Clark was an Atlanta native who was graduated

from Emory University and Cornell University medical college before undertaking postgraduate work at Yale University. During the Korean War he served in the U.S. Navy, then came to Macon and entered private practice.

Professional affiliations included offices of secretary of the Southern Neurosurgical Society, Inc., past president of the Georgia Neurosurgical Society and past vice president of the Congress of Neurological Surgeons. He was a member of Christ Episcopal Church in Macon.

Dr. Clark is survived by his widow, Mrs. Helen Walker Clark; daughter, Miss Helen Walker Clark; son, Robert Allen Clark, III, all of Macon; mother, Mrs. Robert A. Clark, Sr. of Macon; and brother, William Davis Clark of Clearwater, Fla.

John Davis Elder

John Davis Elder, who had practiced 20 years in Athens, died March 5. He was born in 1916.

A graduate of the University of Georgia and the Medical College of Georgia, Dr. Elder was on the staffs of Athens General and St. Mary's hospitals. He held membership in the Crawford W. Long Medical Society, AMA, Georgia State Obstetrical and Gynecological Society and was an Aide de Camp on the Governor's Staff.

Outside interest led him to membership in the Athens Historical Society and the National Historical Society

Survivors include his widow, Mrs. Elizabeth Seuffert Elder; daughter, Miss Elizabeth Anne Elder of Athens; son, John F. Elder of Augusta; three sisters, Mrs. Mary E. Hardegree of Winder, Mrs. Ruth E. Miller of Hollywood, Fla. and Mrs. Anne E. Stephens of Richmond, Va.; four brothers, Paul S. Elder of Bay Pines, Fla., James N. Elder of Clewiston, Fla., Phillips M. Elder and Ira Louis Elder of Winder; several nieces and nephews.

Dallas Norman Thompson

Elberton physician for 65 years, Dallas Norman Thompson died January 27 in Elberton-Elbert County Hospital after a long illness. He was 86.

Dr. Thompson was born in Ila and graduated in 1908 from the Medical College of Georgia. For several years he served on the Georgia State Board of Health, was on the staff of three Georgia governors, and was past president of the Tenth District Medical Association and the Tri-County Medical Association. Dr. Thompson was a member of AMA, fellow of the Southeastern Medical Association and operated Johnson-Thompson Hospital with Dr. Walton Johnson.

In Elberton, Dr. Thompson was a bank director, member and elder of the First Presbyterian Church, Rotarian and member of Woodmen of the World.

He is survived by his widow, Emmie Hambaugh Robinson Thompson; two sons, Lt. Col. Dillard Norman Thompson, USAF retired, of Sumter, S.C. and Brown Thompson of Carlton; step-son, James Robinson of Atlanta; step-daughter, Mrs. James McFarland of Silverton, N.Y.; two sisters, Miss Mamie Thompson of Ila and Mrs. Howard Fowler of Lake City, Fla.; 10 grandchildren and four great-grandchildren.

THE MONTH IN WASHINGTON

The American Medical Association took to Congress its protest against retention of controls over physicians in phase III of the economic stabilization program.

In a statement to the Senate Committee on Banking, Housing and Urban Affairs, which was considering a one-year extension of statutory authority for the program, the AMA cited the "highly discriminatory" treatment of physicians and other health care providers under the program despite their cooperation and "laudable record of self-restraint."

"We have questioned the wisdom of many of the policies which have been initiated in the various regulatory phases since August of 1971," the AMA statement said. "In particular, we have objected to certain aspects because of the highly discriminatory treatment accorded health care providers. This discrimination has been even heightened under phase III of the Administration's program. On January 11, 1973, mandatory wage and price controls were suspended for most sectors of the economy but were continued to be enforced upon health care providers. Our opposition to this discrimination does not stem from self-interest, nor is it based solely upon invidious comparison with those segments of the economy no longer subject to mandatory control. The question we raise here is more fundamental. It is submitted that the capricious imposition of controls on select groups only serves to frustrate the basic objectives of the stabilization program itself. If regulation is to be effective, it must recognize the interrelationships existing within the economy in general. Without such accomplishment the intent of the law will be frustrated.

Impact on Economy

"Physicians' fees constitute a relatively small percentage of the gross national product (less than 1.5 per cent) and they constitute a small factor in the consumer price index weighting structure (less than 1.8 per cent). Given the relatively slight impact of this factor upon the economy as a whole, the suspension of mandatory controls would not work counter to the goals of the economic stabilization program. Conversely, continued controls could not be expected to yield meaningful restraints throughout the balance of the economy. The continuation of mandatory controls, therefore, does not appear to be consistent with the letter or spirit of the economic stabilization act.

"The Congress found in enacting the economic stabilization act that prompt judgments and actions by the executive branch of the government were necessary to meet extreme economic fluctuations. The Congress, however, directed the president to conduct such emergency programs in a fair and equitable manner and to make such adjustments as may be necessary to prevent gross inequities. Standards established under an emergency program must comply with the criteria of section 203 (b) of the act which provides, among other things, that such standards shall be "generally fair and equitable" and that the program must call for "generally comparable sacrifices by business and labor as well as other segments of the economy."

"We emphasize that this statutory authority pre-

sumes the existence of an economic emergency and authorizes a coherent and comprehensive governmental response. Only a system of price stabilization effective at all levels of production and consumption and having equitable incidence within the economy should be countenanced. To invoke controls for one activity without the reasonable expectation of achieving a result having universal application is to employ the statute in a punitive manner. Punitive treatment of health care professionals is neither sanctioned by law nor warranted by the record.

"It is apparent from the physician component of the consumer price index that the medical community has fully complied with efforts to curb inflation during phase I and II of the new economic policy. In the period from August 1971 to December 1972 the all items category, as measured by the consumer price index, rose at a rate of 4.2 per cent, and all services component at the rate of 4.6 per cent, while physicians' fees rose only 3.2 per cent. In the period from November 1971 to December 1972 (i.e., during the 14 months of phase II) the all items category rose 3.8 per cent, the price of all services rose at a rate of 3.8 per cent while physicians' fees rose at a rate of 2.6 per cent. For the calendar year 1972, physicians' fees increased only 2.1 per cent. This percentage is below the 2.5 per cent annual goal set by the Health Services Industry Committee of the Price Commission, and represents a rate of increase of only one third the rate of increase prior to phase I. Since the goal of the economic stabilization program was to halve the rate of inflation, the record achieved by physicians surpassed considerably the expectations of the program. Thus, there is no indication that physicians' fees have been a major inflationary factor during the course of the stabilization program, and it is difficult to discern any rationale for imposing mandatory controls in this sector. Continued controls do not appear to be the just reward for this record of compliance. We submit that this precedent could have a demoralizing effect on other industries which might well conclude that a record of restraint does not preclude imposition of a continued regimen of control. . . .

"All activities require the basic factors of production, and all of us must compete in the marketplace for these necessary goods and services. It will become increasingly difficult for the health care services to obtain needed material and manpower unless the stabilization program is administered in a nondiscriminatory fashion."

Tumor Registry

The National Cancer Institute has established an International Tumor Immunotherapy Registry to serve as a center for collection, storage and exchange of information on immunological methods of treating cancer.

The registry will record physicians' experience with immunotherapy for human cancer, including methods of administration, results of the treatment and possible side effects. It will be kept up-to-date by periodic progress reports from the physicians, who will in turn receive newsletters containing summaries of the most re-

cent information. Computers are expected to handle much of the work involved in maintaining the registry.

Immunological methods of cancer treatment, which stimulate a patient's immune system to attack cancer cells, are increasingly being evaluated against types of cancer not treatable by other methods. Many different approaches are being explored and results have been variable. It is hoped that the rapid communication afforded by the registry will prevent needless duplication of unsuccessful treatment and encourage cooperation in well-controlled studies of promising approaches.

Privilege

The American Medical Association warned of "possible adverse consequences" of abolishing the physician-patient privilege in federal court cases.

The AMA's "deep concern" was expressed in letters from Ernest B. Howard, M.D., AMA executive vice president, to the chairmen of the House and Senate judiciary committees which were considering such an abolition in the proposed new federal rules of evidence.

Dr. Howard reiterated the Association's position that "a qualified physician-patient relationship should be recognized." He said that the pertinent rule in the American Bar Association's Uniform Rules of Evidence would be preferable to the complete abolition of the privilege.

"We urge your committee to consider the effect of the abolition of the general physician-patient privilege noted in our statement and the confusion that may become prevalent if state and federal courts observe different rules when considering evidence based upon confidential communications made by a patient to his attending physician during the course of the physician-patient relationship," Dr. Howard said.

"The American Medical Association, as you will notice, does not advocate that an absolute or unrestricted physician-patient privilege be established. Acceptance of the basic concept of the physician-patient privilege (with limitations and restrictions that assure the proper administration of justice) is vital, however, to avoid abuse of individual rights and inhibition of frank communication essential in the physician-patient relationship."

Private Disclosures

"The physician-patient relationship is traditionally a confidential relationship requiring a high level of trust on the part of the patient. For proper diagnosis and treatment of a patient's illness it is often essential that the patient be encouraged to disclose facts, circumstances, opinions and attitudes concerning his personal or family life. Some of these disclosures are pertinent to the diagnosis and treatment and others are not. The pertinence cannot be determined until the disclosure has been made by the patient and evaluated by the physician.

"The medical profession recognizes also that the proper administration of justice is essential for the welfare of the public, including patients and physicians. It is aware that a rule of complete privilege, such as that applied in the attorney-client relationship can lead to abuses which result in a miscarriage of justice. If a patient uses a broad physician-patient privilege to bar disclosure of relevant information which would ad-

versely affect the outcome of litigation of a liability claim made by him, this abuse of the privilege would be conducive to fraud.

Relevancy

"On the other hand, fraud against a patient could also be perpetrated by threatening to compel his physician to disclose private and confidential information that has little if any relevancy to the issues raised in the litigation. The total abolition of the physician-patient privilege would leave the patient substantially without protection against this kind of abuse. Judicial determination of relevancy alone would not be sufficient protection, since some degree of disclosure would be necessary to obtain the judicial determination.

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Cover

The medical records room of Piedmont Hospital, Atlanta, in the cover photograph, calls attention to a special article and reprint of the law in the May issue. Atlanta photographer Joe MyTyre posed Mrs. Beverly Wilford, R.R.A. (L), records room librarian, and Miss Carolyn Scott. Layout by Atlanta artist Bob Hamill.

The author's view of the law, its meaning and ramifications for Georgia physicians are presented in this special article.

PSRO—Placebo or Therapy?

L. C. BUCHANAN, M.D.,* *Decatur*

ON OCTOBER 30 LAST, the Presidential signature made Public Law 92-603 the law of the land.

Many government officials as well as leaders of our profession, have aptly observed that the implementation of this statute will impact upon the practice of medicine, the medical profession itself, and most importantly, the American people, far greater than has the Medicare program. While a timetable of implementation is precisely specified in the law, the actual design, mechanism of construction, operation and maintenance of the Gargantuan project is left almost entirely to the preassumed wisdom, ability, and philosophic judgements of the Secretary of HEW. The detailed plans and specifications of structure and operation to be promulgated through "administrative regulations" will be made available for our study and appraisal at the pleasure of the Secretary.

Nationwide, in forums varying from elaborate symposia and seminars to dressing room dialogues, PSRO is being "cussed" and debated, acclaimed and denounced and, all too often, the loudest voice is from one having the least familiarity with the facts available from the law as written. Random inquiry recently of 20 practicing physicians in our community revealed only eight with any real conception of what PSRO really is, and only two were able to demonstrate they had read any appreciable amount of the statute as published.

Primary Questions

What and why PSRO? How will it work? Is it voluntary or compulsory law? Is it a good or a "bad" law? If I have a choice, what is it? What relation or

effect does it have with reference to AMA? MAG? The Georgia Medical Care Foundation?

PSRO—Professional Standards Review Organization—is in essence a gigantic structure allegedly to insure "quality control" over the entire gamut of health care services. The most naive student of this law quickly sees that the prime intent of the program is to control and reduce the *cost* of health care. The review process is to insure that fees charged by providers of health care (physicians, osteopaths, podiatrists, and in some cases physical therapists and chiropractors) fall within established "norms." The review is to further determine if the service rendered was indeed "medically necessary" at all, and if so, was the treatment rendered appropriate for the condition; viz., was it rendered in the proper place? (Review will be on services performed in your office, in a hospital as in-patient or out-patient, in an E.C.F., in patient's home, etc., etc.) In cases of in-patient service, was the length of stay within pre-established norms for the diagnosis or condition? Was there overutilization or inappropriate use of drugs, x-rays, laboratory tests? Was surgical treatment necessary?

As regards office services, were the number of visits justifiable for the diagnosis? Was the laboratory testing appropriate or unnecessary? Were x-rays obtained indicated? Were the number and frequency and, yes, the type of injections, within the norms established for that diagnosis? (The present law provides that, "a Medicare audit must encompass review of both Medicare and non-Medicare patient records in order to verify the amount for re-imbbursement to the providers.")*

In an extended care facility, is the beneficiary re-

* Vice President, Board of Directors of the Georgia Medical Care Foundation and Vice Chairman of MAG Council.

* Medicare Regulation 405.405 and 405.454, Paragraph 7645, Note 13, Accessibility of Non-Medicare Patients Medical Records.

ceiving the proper level of care, i.e., does the patient's condition warrant skilled nursing care, intermediate care or custodial care? (Obviously continuing review and repeated evaluation of every patient in every E.C.F. in the nation will be necessary to keep the review opinion current.)

To further enumerate the provisions of the intended review process is beyond the scope of this editorial but the detailed specifics of the review process, and the authority to probe into the minutia of any course of treatment, are all too clearly defined in the law.

Whether the law is a "good" or "bad" law is presently a matter of individual judgement. This writer believes the law to be poorly conceived, impractically designed and impossible to fully implement and enforce. The sheer cost of PSRO establishment and operation will defeat the announced goal of reducing the cost of medical care. The true quality of medical care will suffer immeasurably in the process.

Payment Means Compliance

No physician worthy of our profession can advocate violation of federal law. That is not the question. The PSRO statute does not *compel* a practitioner to participate; however, initially physicians are being sought to actually *be* the PSRO. This is where the water hits the wheel, and it is here that we must make an awesome decision.

No matter who are the bodies actually constituting a PSRO unit, if a practitioner or provider of service accepts *any* payment "in part or in whole" from the government, he (or the institution) absolutely must be constantly "in compliance" with PSRO law and regulations under penalty of retroactively having to repay the estimated (by the Secretary) cost of fee overpayment and/or cost of any overutilization (or \$5,000.00, whichever is smaller). He may also be terminated as a future recipient of any federal payments. If, on the other hand, he refuses to accept payment from the government "in part or in whole" for any service and instead looks to his patient for payment by direct billing, he then is not subject to PSRO law or any of its regulations. This, at least for the present, can be for each of us an individual decision.

Can PSRO Work?

If practicing physicians of integrity, truly concerned for their patients' ultimate good, do not unite and attempt the operational control of PSRO, including an uncompromising demand to be allowed to establish all the "norms" to be used, then (after 1976) the Secretary can proceed to designate others

to constitute the PSRO units. Then the real question: are we being offered a placebo? Is this an impotent, non-specific gesture being offered to our profession with the full knowledge that it cannot really work and therefore help "cure" the high cost of medical care? When it proves to be ineffectual, can the bureaucrats then say, "We gave the Doctors a chance to cut medical costs and they failed! We must now go on to total National Health Insurance."

Or is this really a therapeutic agent with some promise? Can we take it out of the hands of the unskilled laity and demonstrate our unity of purpose to continue quality care to the sick and injured, can we muster the strength of unity and the perceptive leadership necessary to accomplish several things? Will the Congress and the Secretary give us the authority to cut health care costs where we know real savings, big savings, can be effected? If we are controlling PSRO, can we then eliminate the excessive costs incident to overstaffing, inefficiency and costly wastes we have proven through our own Foundation do exist in those non-medical agencies now doing review? Will we be given the authority to review in depth and report the inefficiency and wastes only doctors know exist in many areas of hospital services? Would we as PSRO at our local level (where the Congress has stated PSRO should operate) be allowed to direct the level, and therefore the cost, of necessary E.C.F. patient care? These may seem unlikely but they are possibilities. The real cost savings that can be effected in the overall health care system in this country is not in further cutting doctors fees but in some of the areas just enumerated. It is an outworn cliché but it is now obvious that either "we do it or they will."

Georgia's Situation

The AMA originally opposed PSRO during legislative hearings we are told. AMA now is advocating full physician participation, presumably on the premise that since we are being offered it initially, we can be in a position of policy making, "norm" and standard determination, etc., from the beginning.

MAG cannot legally serve as a statewide PSRO. This is obvious since all practicing physicians in a designated PSRO area are affected by, and must be eligible to participate in, a PSRO unit and all practitioners in Georgia are not members of MAG. We have obtained opinion of MAG legal counsel on this point.

The Georgia Medical Care Foundation could serve as a PSRO with some minor changes in its By-Laws, but the advice has been obtained that it would be advisable for MAG to set up an entirely separate PSRO unit and MAG Council is to be

asked to do this in the near future. The Council of MAG has requested the Secretary of HEW to designate the entire state of Georgia as a PSRO "service area," a step which must be accomplished before any group can be designated as a PSRO.

What can you do?

You can study public law 92-603 which follows this article and read the extracted pertinent portions of the Report of the Senate Finance Report of September 26, 1972. (Available in limited numbers from MAG headquarters. Reading time—both approximately one and a half to two hours.)

You can give careful, prayerful thought and introspection regarding what is the wisest decision to be made by you as an individual and all of us collectively.

You, and I, and all of us, had better realize again that whatever the true majority decision is on this vital and complex problem, unless we present a united front to the onslaught, we and those who follow us will probably never see quality medicine practiced as in the past and present.

PSRO—placebo, or therapy. . . ?

374 W. Ponce de Leon Avenue 30030

PUBLIC LAW 92-603

The following is a reprint of provisions of the "Social Security Amendments of 1972," passed by the 92nd Congress October 30, 1973, which relate to Professional Standards Review Organizations and pertinent Medicare amendments.

"TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW"

"Part A—General Provisions"

(b) Title XI of such Act is further amended by adding the following:

"Part B—Professional Standards Review"

"DECLARATION OF PURPOSE"

"Sec. 1151. In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional standards for the provision of health care and that payment for such services will be made—

"(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

"(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

"DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

"Sec. 1152. (a) The Secretary shall (1) not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and (2) at the earliest practicable date after designation of an area enter into an agreement with a qualified organization whereby

such an organization shall be conditionally designated as the Professional Standards Review Organization for such area. If, on the basis of its performance during such period of conditional designation, the Secretary determines that such organization is capable of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization under this part, he shall enter into an agreement with such organization designating it as the Professional Standards Review Organization for such area.

"(b) For purposes of subsection (a), the term 'qualified organization' means—

"(1) when used in connection with any area—

"(A) an organization (i) which is a non-profit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c) (i).

"(B) such other public, non-profit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable; and

"(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan submitted to him by the association, agency, or organization (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and activities of a Professional Standards Review Organization required by or pursuant to this part.

"(c) (1) The Secretary shall not enter into any agreement under this part under which there is designated as the

Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A) prior to January 1, 1976, nor after such date, unless, in such area, there is no organization referred to in subsection (b) (1) (A) which meets the conditions specified in subsection (b) (2).

"(2) Whenever the Secretary shall have entered into an agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A), he shall not renew such agreements with such organization if he determines that—

"(A) there is in such area an organization referred to in subsection (b) (1) (A) which (i) has not been previously designated as a Professional Standards Review Organization, and (ii) is willing to enter into an agreement under this part under which such organization would be designated as the Professional Standards Review Organization for such area;

"(B) such organization meets the conditions specified in subsection (b) (2); and

"(C) the designation of such organization as the Professional Standards Review Organization for such area is anticipated to result in substantial improvement in the performance in such area of the duties and functions required of such organizations under this part.

"(d) Any such agreement under this part with an organization (other than an agreement established pursuant to section 1154) shall be for a term of 12 months; except that, prior to the expiration of such term such agreement may be terminated—

"(1) by the organization at such time and upon such notice to the Secretary as may be prescribed in regulations (except that notice of more than 3 months may not be required); or

"(2) by the Secretary at such time and upon such reasonable notice to the organization as may be prescribed in regulations, but only after the Secretary has determined (after providing such organization with an opportunity for a formal hearing on the matter) that such organization is not substantially complying with or effectively carrying out the provisions of such agreement.

"(e) In order to avoid duplication of functions and unnecessary review and control activities, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under or pursuant to any provision of this Act (other than this part) where he finds, on the basis of substantial evidence of the effective performance of review and control activities by Professional Standards Review Organizations, that the review, certification, and similar activities otherwise so required are not needed for the provision of adequate review and control.

"(f) (1) In the case of agreements entered into prior to January 1, 1976, under this part under which any organization is designated as the Professional Standards Review Organization for any area, the Secretary shall, prior to entering into any such agreement with any organization for any area, inform (under regulations of the Secretary) the doctors of medicine or osteopathy who are in active practice in such area of the Secretary's intention to enter into such an agreement with such organization.

"(2) If, within a reasonable period of time following the serving of such notice, more than 10 per centum of such doctors object to the Secretary's entering into such an agreement with such organization on the ground that such organization is not representative of doctors in such area, the Secretary shall conduct a poll of such doctors to determine whether or not such organization is representative of such doctors in such area. If more than 50 per centum of the doctors responding to such poll indicate that such organization is not representative of such doctors in such area the Sec-

retary shall not enter into such an agreement with such organization.

"REVIEW PENDING DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION"

"Sec. 1153. Pending the assumption by a Professional Standards Review Organization for any area, of full review responsibility, and pending a demonstration of capacity for improved review effort with respect to matters involving the provision of health care services in such area for which payment (in whole or in part) may be made, under this Act, any review with respect to such services which has not been designated by the Secretary as the full responsibility of such organization, shall be reviewed in the manner otherwise provided for under law.

"TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

"Sec. 1154. (a) The Secretary shall initially designate an organization as a Professional Standards Review Organization for any area on a conditional basis with a view to determining the capacity of such organization to perform the duties and functions imposed under this part on Professional Standards Review Organizations. Such designation may not be made prior to receipt from such organization and approval by the Secretary of a formal plan for the orderly assumption and implementation of the responsibilities of the Professional Standards Review Organization under this part.

"(b) During any such trial period (which may not exceed 24 months), the Secretary may require a Professional Standards Review Organization to perform only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided or ordered by physicians and other practitioners and institutional and other health care facilities, agencies, and organizations. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

"(c) Any agreement under which any organization is conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon 90 days notice to the Secretary or by the Secretary upon 90 days notice to such organization.

"DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

"Sec. 1155. (a) (1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall (subject to the provisions of subsection (g)) be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

"(A) such services and items are or were medically necessary;

"(B) the quality of such services meets professionally recognized standards of health care; and

"(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

"(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

"(A) any elective admission to a hospital, or other health care facility, or

"(B) any other health care service which will consist of extended or costly courses of treatment, whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).

"(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order most effectively to carry out the purpose of this part, exercise the authority conferred upon it under paragraph (2).

"(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

"(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization and (except as may be otherwise provided under subsection (e) (1) of this section) such physicians ordinarily should not be responsible for, but may participate in the review of care and services provided in any hospital in which such physicians have active staff privileges.

"(6) No physician shall be permitted to review—

"(A) health care services provided to a patient if he was directly or indirectly involved in providing such services, or

"(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, any financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

"(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—

"(1) make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization;

"(2) undertake such professional inquiry before or after,

or both before and after, the provision of services with respect to which such organization has a responsibility for review under subsection (a) (1);

"(3) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a) (1); and

"(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

"(c) No Professional Standards Review Organization shall utilize the services of any individual who is not a duly licensed doctor of medicine or osteopathy to make final determinations in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine or osteopathy, or any act performed by any duly licensed doctor of medicine or osteopathy in the exercise of his profession.

"(d) In order to familiarize physicians with the review functions and activities of Professional Standards Review Organizations and to promote acceptance of such functions and activities by physicians, patients, and other persons, each Professional Standards Review Organization, in carrying out its review responsibilities, shall (to the maximum extent consistent with the effective and timely performance of its duties and functions)—

"(1) encourage all physicians practicing their profession in the area served by such Organization to participate as reviewers in the review activities of such Organizations;

"(2) provide rotating physician membership of review committees on an extensive and continuing basis;

"(3) assure that membership on review committees have the broadest representation feasible in terms of the various types of practice in which physicians engage in the area served by such Organization; and

"(4) utilize, whenever appropriate, medical periodicals and similar publications to publicize the functions and activities of Professional Standards Review Organizations.

"(e) (1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital or other operating health care facility or organization located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity effectively and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a) (1), except where the Secretary disapproves, for good cause, such acceptance.

"(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

"(f) (1) An agreement entered into under this part between the Secretary and any organization under which such organization is designated as the Professional Standards Review Organization for any area shall provide that such organization will—

"(A) perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part; and

"(B) collect such data relevant to its functions and such information and keep and maintain such records in such form as the Secretary may require to carry out the purposes of this part and to permit access to and use of any such records as the Secretary may require for such purposes.

"(2) Any such agreement with an organization under this part shall provide that the Secretary make payments to such organization equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by

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such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

“(g) Notwithstanding any other provision of this part, the responsibility for review of health care services of any Professional Standards Review Organization shall be the review of health care services provided by or in institutions, unless such Organizations shall have made a request to the Secretary that it be charged with the duty and function of reviewing other health care services and the Secretary shall have approved such request.

“NORMS OF HEALTH CARE SERVICES FOR VARIOUS ILLNESSES OR HEALTH CONDITIONS”

“Sec. 1156. (a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (including typical lengths of stay for institutional care by age and diagnosis) as principal points of evaluation and review. The National Professional Standards Review Council and the Secretary shall provide such technical assistance to the organization as will be helpful in utilizing and applying such norms of care, diagnosis, and treatment. Where the actual norms of care, diagnosis, and treatment in a Professional Standards Review Organization area are significantly different from professionally developed regional norms of care, diagnosis, and treatment approved for comparable conditions, the Professional Standards Review Organization concerned shall be so informed, and in the event that appropriate consultation and discussion indicate reasonable basis for usage of other norms in the area concerned, the Professional Standards Review Organization may apply such norms in such area as are approved by the National Professional Standards Review Council.

“(b) Such norms with respect to treatment for particular illnesses or health conditions shall include (in accordance with regulations of the Secretary)—

“(1) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;

“(2) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

“(c) (1) The National Professional Standards Review Council shall provide for the preparation and distribution, to each Professional Standards Review Organization and to each other agency or person performing review functions with respect to the provision of health care services under this Act, of appropriate materials indicating the regional norms to be utilized pursuant to this part. Such data concerning norms shall be reviewed and revised from time to time. The approval of the National Professional Standards Review Council of norms of care, diagnosis, and treatment shall be based on its analysis of appropriate and adequate data.

“(2) Each review organization agency, or person referred to in paragraph (1) shall utilize the norms developed under this section as a principal point of evaluation and review for determining, with respect to any health care services which have been or are proposed to be provided, whether such care and services are consistent with the criteria specified in section 1155 (a) (1).

“(d) (1) Each Professional Standards Review Organization shall—

“(A) in accordance with regulations of the Secretary,

specify the appropriate points in time after the admission of a patient for inpatient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further inpatient care in such institution will be medically necessary effectively to meet the health care needs of such patient; and

“(B) require that there is included in any such certification with respect to any patient such information as may be necessary to enable such organization properly to evaluate the medical necessity of the further institutional health care recommended by the physician executing such certification.

“(2) The points in time at which any such certification will be required (usually, not later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnoses) shall be consistent with and based on professionally developed norms of care and treatment and data developed with respect to length of stay in health care institutions of patients having various illnesses, injuries, or health conditions, and requiring various types of health care services or procedures.

“SUBMISSION OF REPORTS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS”

“Sec. 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by section 1160, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such organization is located together with the recommendations of such Organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional comments or recommendations thereon as it deems appropriate. The Secretary may utilize a Professional Standards Review Organization, in lieu of a program review team as specified in sections 1862 and 1866, for purposes of subparagraph (C) of section 1862 (d) (1) and subparagraph (F) of section 1866 (b) (2).

“REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS”

“Sec. 1158. (a) Except as provided for in section 1159, no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

“(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

“(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

“(b) Whenever any Professional Standards Review Organization, in the discharge of its duties and functions as specified by or pursuant to this part, disapproves of any health care services or items furnished or to be furnished by any practitioner or provider, such organization shall, after notifying the practitioner, provider, or other organization or agency of its disapproval in accordance with subsection (a),

promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services or items.

"HEARINGS AND REVIEW BY SECRETARY"

"Sec. 1159. (a) Any beneficiary or recipient who is entitled to benefits under this Act (other than title V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1155 (a) shall, after being notified of such determination, be entitled to a reconsideration thereof by the Professional Standards Review Organization and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is \$100 or more, such determination shall be reviewed by professional members of such Council and, if the Council so determined, revised.

"(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is \$100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205 (b), and, where the amount in controversy is \$1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205 (g). The Secretary will render a decision only after appropriate professional consultation on the matter.

"(c) Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this Act with respect to the same issue.

"OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW"

"Sec. 1160. (a) (1) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act—

"(A) will be provided only when, and to the extent, medically necessary; and

"(B) will be of a quality which meets professionally recognized standards of health care; and

"(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities;

and it shall be the obligation of any health care practitioner in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency), of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

"(D) only when, and to the extent, medically necessary; and

"(E) will be of a quality which meets professionally recognized standards of health care.

"(2) Each health care practitioner, and each hospital or other provider of health care services, shall have an obligation,

within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of its business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

"(A) inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

"(B) (i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

"(ii) (in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type) there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

"(b) (1) If after reasonable notice and opportunity for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has—

"(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or

"(B) by grossly and flagrantly violating any such obligation in one or more instances, demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis.

"(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in title XVIII with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

"(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide such health care services on a reimbursable basis) such practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) \$5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.

"(4) Any person furnishing services described in para-

graph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205 (b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205 (g).

"(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

"NOTICE TO PRACTITIONER OR PROVIDER"

"Sec. 1161. Whenever any Professional Standards Review Organization takes any action or makes any determination—

"(a) which denies any request, by a health care practitioner or other provider of health care services, for approval of a health care service or item proposed to be ordered or provided by such practitioner or provider; or

"(b) that any such practitioner or provider has violated any obligation imposed on such practitioner or provider under section 1160, such organization shall, immediately after taking such action or making such determination, give notice to such practitioner or provider of such determination and the basis therefor, and shall provide him with appropriate opportunity for discussion and review of the matter.

"STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS; ADVISORY GROUPS TO SUCH COUNCILS"

"Sec. 1162. (a) In any State in which there are located three or more Professional Standards Review Organizations, the Secretary shall establish a Statewide Professional Standards Review Council.

"(b) The membership of any such Council for any State shall be appointed by the Secretary and shall consist of—

"(1) one representative from and designated by each Professional Standards Review Organization in the State;

"(2) four physicians, two of whom may be designated by the State medical society and two of whom may be designated by the State hospital association of such State to serve as members on such Council; and

"(3) four persons knowledgeable in health care from such State whom the Secretary shall have selected as representatives of the public in such State (at least two of whom shall have been recommended for membership on the Council by the Governor of such State).

"(c) It shall be the duty and function of the Statewide Professional Standards Review Council for any State, in accordance with regulations of the Secretary, (1) to coordinate the activities of, and disseminate information and data among the various Professional Standards Review Organizations within such State including assisting the Secretary in development of uniform data gathering procedures and operating procedures applicable to the several areas in a State (including, where appropriate, common data processing operations serving several or all areas) to assure efficient operation and objective evaluation of comparative performance of the several areas and, (2) to assist the Secretary in evaluating the performance of each Professional Standards Review Organization, and (3) where the Secretary finds it necessary to replace a Professional Standards Review Organi-

zation, to assist him in developing and arranging for a qualified replacement Professional Standards Review Organization.

"(d) The Secretary is authorized to enter into an agreement with any such Council under which the Secretary shall make payments to such Council equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such Council in carrying out the duties and functions provided in this section.

"(e) (1) The Statewide Professional Standards Review Council for any State (or in a State which does not have such Council, the Professional Standards Review Organizations in such State which have agreements with the Secretary) shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

"(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council (or Professional Standards Review Organizations in States without such Councils).

"(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such group in carrying out its duties and functions under this subsection shall be considered to be expenses necessarily incurred by the Statewide Professional Standards Review Council served by such group.

"NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL"

"Sec. 1163. (a) (1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the 'Council') which shall consist of eleven physicians, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

"(2) Members of the Council shall be appointed for a term of three years and shall be eligible for reappointment.

"(3) The Secretary shall from time to time designate one of the members of the Council to serve as Chairman thereof.

"(b) Members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

"(c) The Council is authorized to utilize, and the Secretary shall make available, or arrange for, such technical and professional consultative assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical and other assistance and such pertinent data prepared by, for, or otherwise available to, the Department of Health, Education, and Welfare as the Council may require to carry out its functions.

"(d) Members of the Council, while serving on business of the Council, shall be entitled to receive compensation at a rate fixed by the Secretary (but not in excess of the daily rate paid under GS-18 of the General Schedule under section 5332 of title 5, United States Code), including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by sec-

tion 5703 of title 5, United States Code, for persons in Government service employed intermittently.

"(e) It shall be the duty of the Council to—

"(1) advise the Secretary in the administration of this part;

"(2) provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations of information and data which will assist such review councils and organizations in carrying out their duties and functions;

"(3) review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of this part; and

"(4) make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of this part.

"(f) The National Professional Standards Review Council shall from time to time, but not less often than annually, submit to the Secretary and to the Congress a report on its activities and shall include in such report the findings of its studies and investigations together with any recommendations it may have with respect to the more effective accomplishment of the purposes and objectives of this part. Such report shall also contain comparative data indicating the results of review activities, conducted pursuant to this part, in each State and in each of the various areas thereof.

"APPLICATION OF THIS PART TO CERTAIN STATE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE"

"Sec. 1164. (a) In addition to the requirements imposed by law as a condition of approval of a State plan approved under any title of this Act under which health care services are paid for in whole or part, with Federal funds, there is hereby imposed the requirement that provisions of this part shall apply to the operation of such plan or program.

"(b) The requirement imposed by subsection (a) with respect to such State plans approved under this Act shall apply—

"(1) in the case of any such plan where legislative action by the State legislature is not necessary to meet such requirement, on and after January 1, 1974; and

"(2) in the case of any such plan where legislative action by the State legislature is necessary to meet such requirement, whichever of the following is earlier—

"(A) on and after July 1, 1974, or

"(B) on and after the first day of the calendar month which first commences more than ninety days after the close of the first regular session of the legislature of such State which begins after December 31, 1973.

"CORRELATION OF FUNCTIONS BETWEEN PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AND ADMINISTRATIVE INSTRUMENTALITIES"

"Sec. 1165. The Secretary shall by regulations provide for such correlation of activities, such interchange of data and information, and such other cooperation consistent with economical, efficient, coordinated, and comprehensive implementation of this part (including, but not limited to, usage of existing mechanical and other data-gathering capacity) between and among—

"(a) (1) agencies and organizations which are parties to agreements entered into pursuant to section 1816, (2) carriers which are parties to contracts entered into pursuant to section 1842, and (3) any other public or private agency (other than a Professional Standards Review Organization)

having review or control functions, or proved relevant data-gathering procedures and experience, and

"(b) Professional Standards Review Organizations, as may be necessary or appropriate for the effective administration of title XVIII, or State plans approved under this Act.

"PROHIBITION AGAINST DISCLOSURE OF INFORMATION"

"Sec. 1166. (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care.

"(b) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than \$1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

"LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION, AND FOR MEMBERS AND EMPLOYEES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, AND FOR HEALTH CARE PRACTITIONERS AND PROVIDERS"

"Sec. 1167. (a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) unless—

"(1) such information is unrelated to the performance of the duties and functions of such Organization, or

"(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

"(b) (1) No individual who, as a member or employee of any Professional Standards Review Organization or who furnishes professional counsel or services to such organization, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of Professional Standards Review Organizations under this part, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) provided he has exercised due care.

"(2) The provisions of paragraph (1) shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

"(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by a Professional Standards Review Organization (which has been designated in accordance with section 1152 (b) (1) (A) operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

"(1) he takes such action (in the case of a health care practitioner) in the exercise of his profession as a doctor of medicine or osteopathy (or in the case of a provider of health care services) in the exercise of his functions as a provider of health care services, and

"(2) he exercised due care in all professional conduct

taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

"AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE PROVISIONS OF THIS PART"

"Sec. 1168. Expenses incurred in the administration of this part shall be payable from—

"(a) funds in the Federal Hospital Insurance Trust Fund;

"(b) funds in the Federal Supplementary Medical Insurance Trust Fund; and

"(c) funds appropriated to carry out the health care provisions of the several titles of this Act; in such amounts from each of the sources of funds (referred to in subsections (a), (b), and (c) as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of this part with respect to each of such plans and programs.

"TECHNICAL ASSISTANCE TO ORGANIZATIONS DESIRING TO BE DESIGNATED AS PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

"Sec. 1169. The Secretary is authorized to provide all necessary technical and other assistance (including the preparation of prototype plans of organization and operation) to organizations described in section 1152 (b) (1) which—

"(a) express a desire to be designated as a Professional Standards Review Organization; and

"(b) the Secretary determines have a potential for meeting the requirements of a Professional Standards Review Organization; to assist such organizations in developing a proper plan to be submitted to the Secretary and otherwise in preparing to meet the requirements of this part for designation as a Professional Standards Review Organization.

"EXEMPTIONS OF CHRISTIAN SCIENCE SANATORIUMS"

"Sec. 1170. The provisions of this part shall not apply with respect to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

CANDLER HOSPITAL IMPORTS PHILIPPINE NURSES FOR STAFF

Fifteen registered nurses from the Philippines have just arrived in Savannah to join the staff of Candler General Hospital.

The nurses were selected recently by Dan Maddock, director of patient care, and Mrs. Beverly Kennedy, director of nursing services at Candler General, who spent about two weeks in the Philippines in February looking into the quality of education and caliber of candidates.

Mrs. Kennedy reported that she and Maddock were highly impressed by their findings and contracted for 15 nurses to join the staff of approximately 200 nurses at Candler.

The majority of the nurses who have come to Candler have completed five-year bachelor of science in nursing degree training, she said. All have a minimum

of one year's experience and have passed their state board examinations in the Philippines. Also, Mrs. Kennedy added, they will be expected to pass their board examinations in the State of Georgia.

Hospital President Robert J. Marsh explained that many hospitals in the country have employed nurses in this manner to increase the professional components of their staffs. Candler representatives, he said, visited many of these hospitals and received reports of "the exceptional caliber of training these nurses have received." Mrs. Kennedy said that hospitals in Valdosta, Rome and Jesup in Georgia already have recruited nurses in this manner.

The nurses will have a one-year contract, and their visa allows them to remain for an additional year if they wish to do so. Ranging in age from 23 to 32, the group includes one male nurse and 14 female nurses.

The basic defect is believed to be an abnormal sphincteric mechanism.

Surgical Treatment of Hereditary Pancreatitis: Report of a Case

H. T. EDMONDSON, M.D. and WILLIAM C. HOLMES, M.D.,* Augusta

CHRONIC PANCREATITIS can often be reasonably explained as a consequence of various conditions with which it is usually associated such as biliary tract disorder, or excessive alcohol intake. In some cases, however, it cannot be readily explained, which has prompted considerable inquiry into its nature. In recent years several reports have documented the fact that chronic pancreatitis can appear, without obvious cause, among multiple members of one family, suggesting that it is a heritable disease in these instances. Furthermore, there is evidence to suggest that congenital hypertrophy of the sphincter of Oddi may constitute the underlying defect; and if treated sufficiently early, the disease is amenable to corrective surgical treatment.

Case Report

A 35-year-old white male was admitted to the Veterans Administration Hospital for evaluation and treatment of chronic pancreatitis. His symptoms began at the age of five years and consisted of attacks of constant, deep, and very severe mid-epigastric pain, which usually lasted two to three days. The pain sometimes began spontaneously, but its onset usually was associated with fatty food intake. Abstinence from food appeared to be the only source of relief. The attacks occurred two or three times a year, and for the past three years had increased markedly in severity and with deep radiation to the back. He also described frequent "explosive" diarrheal attacks related to excessive fatty food intake.

The family history was quite significant (Figure 1).

The grandmother (I-1) had recurrent abdominal pain all her life that was strongly suggestive of pancreatitis. She was a diabetic in later years.

The father (II-4) of our patient had characteristic

recurrent abdominal pain occurring at age five. He now has rare attacks. He has pancreatic calcifications and an abnormal glucose tolerance curve.

Our patient's brother (III-11) had pancreatitis diagnosed at age three and underwent a celiac ganglionectomy to relieve pain. He is still symptomatic.

One first cousin (III-1) committed suicide at age 24. He had a lifelong history of recurrent abdominal pain. He was operated on and told he had carcinoma of pancreas, and lived five months thereafter.

Another first cousin (III-2) was the only member of the family to be an alcoholic. He was diagnosed as having pancreatitis at age 35. He was a mild diabetic.

Each of the two affected first cousins had one child with pancreatitis. One (IV-1) is now 30 years of age and has had a mild course with the onset at age ten.

The child (IV-3) of the other first cousin is now 15 years old and became symptomatic at age ten. He has had recurrent episodes of two to three days at approximately six-month intervals for the past five years.

On physical examination the upper abdomen was

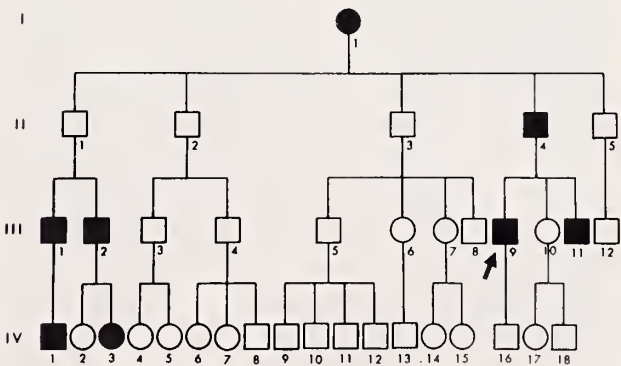


FIGURE 1

Pedigree of family exhibiting hereditary pancreatitis. Males (squares) and females (circles) who are affected are shaded black. Propositus is III-9.

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PANCREATITIS / Edmondson, Holmes

diffusely tender to deep palpation, but particularly in the left upper quadrant. His clinical laboratory evaluation revealed abnormally high blood and urine amylase levels, and a marked reduction in pancreatic excretory function (by secretin stimulation test). Intravenous cholangiogram showed normal gallbladder and bile ducts. No pancreatic calcifications were seen on any of the x-ray films.

Surgical Discoveries

The patient was surgically explored. An operative cholangiogram was performed which revealed a slight dilatation of the distal main pancreatic duct, suggesting a partial obstruction of the terminal pancreatic duct (Figure 2). The papilla of Vater was definitely larger than usual and subsequent histologic sections of the sphincter revealed hypertrophy. A grooved director was inserted into the ampullary opening and the sphincter incised, which revealed separate bile and pancreatic duct openings. The grooved director was then introduced into the pancreatic duct with an abrupt release of several cubic centimeters of grey, muddy, pancreatic fluid which



FIGURE 2

Operative cholangiogram (retouched) to show obstruction of distal pancreatic duct of Wirsung.

was laced with fine gravel. A sphincteroplasty was then performed, the details of which will be discussed subsequently.

Next the accessory pancreatic duct of Santorini was identified and its opening enlarged by incising over a grooved director and suturing the edges apart with chromic 5-0 gut.

The postoperative course was entirely uneventful. Follow-up "T" tube cholangiogram on the tenth postoperative day showed easy access of dye into the duodenum. The accessory pancreatic duct of Santorini was also demonstrated to be patent. In the early postoperative weeks the patient repeatedly commented that he no longer had the deep discomfort which had been present in the preoperative state.

Questions and Answers

Comfort and Steinberg¹ in 1952 were the first to report chronic relapsing pancreatitis in several members of one family. Since that time other kindreds with the disease have been reported in sufficient numbers to firmly establish it as a heritable condition.^{2, 3, 5, 7, 8, 9, 11}

Robeck⁷ first suggested that the etiology may be mechanical obstruction and amenable to surgical rather than to medical therapy. He reported three members of a family who had typical hereditary relapsing pancreatitis and all three had hypertrophy of the sphincter of Oddi.

The question arises: by what method can a hypertrophied sphincter selectively obstruct the distal pancreatic duct without obstructing the common bile duct? The answer lies in the proper appreciation of the complex of sphincters which normally affect the common and pancreatic ducts in their intramural course.

Jones and Smith⁴ in 1971 described three distinct sphincteric mechanisms which affect the common bile and pancreatic ducts as they pass obliquely through the duodenal wall: First, they are affected by the contraction and relaxation of the bowel musculature. Second, there is a submucosal muscular sheath that surrounds both ducts which may contract independently of the duodenal musculature or in conjunction with it and reduce the luminal size of the ducts. Whether the obstruction is partial or complete would in part depend upon the relative original size of each duct. As the pancreatic duct is normally the smaller of the two, it would logically be affected to the greatest extent. Third, at the distal end the submucosal fibers specialize to form the papillary sphincter of Oddi.

We propose that this sphincteric mechanism is capable of selectively obstructing the pancreatic duct

because of its smaller size. We also agree with Jones and Smith⁴ that the obstruction cannot be eliminated by simple incision of the distal papillary sphincter of Oddi, or by "sphincterotomy." Accordingly, the sphincter complex was eliminated in our patient by carrying the incision through the entire thickness of the duodenal wall, a procedure more appropriately described by the term "sphincteroplasty." The technique of this procedure is as follows (Figure 3):

After the papillary sphincter has been incised over a grooved director, two small hemostats are then placed into the common duct for hemostasis. The opening is enlarged by serial clamping, division, and suture approximation of the duodenal and common duct walls. This creates, in effect, an end-to-side choledocho-duodenostomy performed transduodenally. This procedure not only transects the papillary sphincter but also an additional sphincter which ensheathes together the common bile and pancreatic ducts. The avascular septum usually found between the two ducts is incised; this relieves any narrowing of the pancreatic duct.

Some recommend cholecystectomy after completion of the sphincteroplasty because the gallbladder will no longer function. We omitted cholecystectomy to avoid prolonged anesthesia because the overall procedure had extended in duration to the point that we felt further anesthesia time could not easily be justified.

The existence of a specialized ensheathing sphincter within the duodenal wall, as well as specialized "peristaltic-like" activity by the duodenal wall musculature, has been documented by Wakim.¹⁰

It appears that the responsible defect is inherited in an autosomal dominant manner. Examination of our patient's pedigree suggests a "skipped generation," which can be explained on the basis of failure of penetrance of the autosomal dominant mutant gene responsible for the disease (No. II-1 in pedigree, Figure 1). Such individuals, if subjected to close scrutiny, will usually show mild manifestations, which may have been the case here. It is well-known that dominant traits vary in severity or expressivity and are subject to considerable modification by both the effects of other genes and environmental factors. In other words, it is reasonable to assume that the same degree of alcoholic indulgence, for example, may produce pancreatitis in the individual whose sphincteric mechanism is abnormal but not in the person without such a defect.

Summary

A case of hereditary pancreatitis has been presented. Our case adds support to the belief that the heritable defect is an anatomical one—an abnormal sphincteric mechanism with blockage of pancreatic

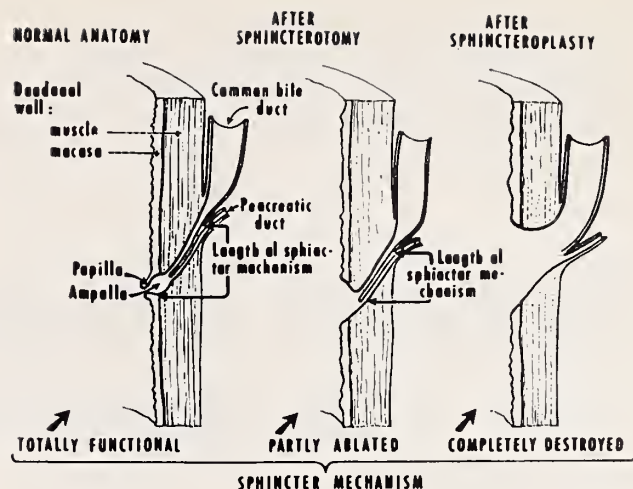


FIGURE 3

Diagram of sphincter mechanism, before and after surgical ablation (after Jones and Smith, reference no. 4).

outflow—and therefore is surgically correctable, at least in its early stages before irreversible pancreatic damage occurs. It is possible that hereditary pancreatitis differs from acquired pancreatitis only in the fact that it occurs earlier in life and without obvious cause, such as alcoholism or biliary tract disease. Early surgical exploration is indicated in suspected cases of hereditary pancreatitis. An adequate sphincteroplasty should be carried out to insure complete ablation of the entire sphincteric mechanism.

We are grateful to Dr. Robert L. Summitt of the Genetics Section, Dept. of Pediatrics, University of Tennessee, Memphis, Tenn., for his suggestions and criticisms in the preparation of this manuscript.

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This non-invasive technique which analyzes a sound "signature" would appear to be useful in the detection of prosthetic valve malfunction.

Evaluation of Prosthetic Valve Function By Octave Band Analysis

EDWARD B. WAXLER, M.D., BENEDICT KINGSLEY, M.Sc., and BERNARD SEGAL, M.D.
*with the technical assistance of PETER GREEN, M.T., Philadelphia, Pa. and Waycross**

THROMBOSIS AND BALL VALVE VARIANCE (BVV) are important complications of prosthetic cardiac valve insertion and may lead to their mechanical dysfunction.¹ BVV is a physicochemical abnormality of the silastic material of the poppet causing swelling, grooving or other degenerative changes usually several years after operation. The Starr-Edwards (S-E) aortic #1000 model has been most frequently involved although other types of silastic prostheses with this complication have been reported at both mitral² and aortic location.³ The clinical manifestations may be syncope, sudden death, valvular insufficiency, or heart failure and auscultation may show diminished prosthetic clicks.

Laboratory detection of ball variance has been accomplished by finding a reduced ratio of aortic opening click (AO) to closing click (AC),⁴ a reduced frequency of AO by sound spectrography⁵ and an abnormal radiographic appearance of the poppet.⁶

Sound Signature

In modern industry, testing the function of certain machines is readily done non-destructively by evaluating the sounds emitted.⁷ This is accomplished by devices that measure the energy level and frequency spectra of vibrations. A sound "signature" is analyzed and malfunction thus determined. In a similar fashion the performance of prosthetic valves was determined non-invasively by octave band analysis (OBA) of the clicks.

Definitions of terms related to sound and its measurement⁷ are given below.

The *decibel* (dB) is a unit of the sound pressure level and is one-tenth of a bel. It is a logarithmic ratio and has a reference level of 20 micronewtons per square meter.

The *frequency* in cycles per second or hertz (Hz) is the time rate of repetition of a periodic phenomenon.

An *octave band* is the interval between two sounds having a basic frequency ratio of two to one and is logarithmic. The preferred series covers 10 bands with center frequencies at 31.5, 63, 125, 250, 500, 1000, and 16,000 Hz. The effective band of 1000, for example, would be from 707 to 1414 Hz.

Octave band analysis (OBA) is the name we have designated to the method for measurement of the prosthetic heart sounds. The system consists of a transducer, a preamplifier, a noise analyzer with an output meter, an oscilloscope and an electrocardiogram.

OBA Equipment

Figure 1 shows the equipment used for OBA, starting with a cylindrical transducer (GR 1560 P54) weighing 90 gms. and having a flat frequency response from 20 to 2000 Hz served as the vibration pick-up device. This is attached to an Octave Band Noise Analyzer (Gr type 1558 BP) which has a flat response from 20 to 8000 Hz. The sensitivity was increased from 44 to 24 dB by a preamplifier (GR 1560 P40K). The octave band filters are set at previously described center frequencies and all pass (AP) in which all frequencies are unattenuated. The analyzer may be calibrated by use of a vibrations calibratory (GR 1557A) which intro-

* From the Cardiology Section, Hahnemann Medical College and Hospital, Philadelphia, Pa. and Waycross Memorial Hospital, Waycross, Ga. This work appeared in part in abstract form in the October 1970 issue of *Circulation*.

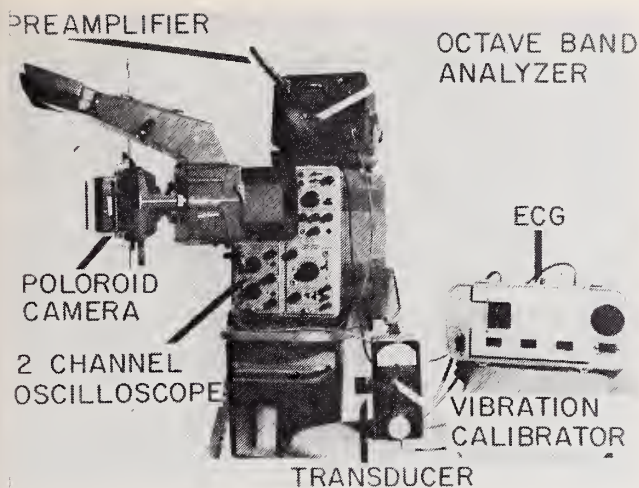


FIGURE 1

The component parts of OBA are shown and include transducer, preamplifier, noise analyzer, oscilloscope, camera, electrocardiogram machine, and a vibration calibrator.

duces an acceleration of 1 gm. at a frequency of 100 Hz.

The sound from the analyzer could be further evaluated for waveform by a cathode ray oscilloscope (Tetronix type 564 Storage Oscilloscope). The second channel of the oscilloscope was attached to the output from a standard electrocardiogram machine and the two channels were recorded simultaneously. A Polaroid camera was attached to the oscilloscope screen and a photograph obtained.

Methods

The patients were studied in the supine position, in midexpiration, and in a quiet room. The transducer was placed on the chest in the 2nd intercostal space to the right of the sternum (area AA) and at the 4th intercostal space to the left of the sternal border (area 4LSB). The transducer rested by its own weight and not externally applied pressure.

The decibel level of the prosthetic clicks was recorded at all octave bands by noting the deflections of the meter on the noise analyzer. The opening and closing clicks could be distinguished by simultaneous timing with the deflections on the oscilloscope. This was difficult, however, when the heart rate was greater than 100 and these beats were not used.

An average of 10 beats for each measurement of dB was used and these values were plotted against the centerband frequency to produce a frequency analysis. The cutoff or peak frequency of the clicks was taken as the centerband frequency at which no meter deflection was first obtained. This corresponds to a sound energy level of 24 dB since this was the lower limit of sensitivity of the system.

A photograph of the oscilloscope screen was obtained at all frequency levels. The amplitude of the deflections could be precisely measured in volts per centimeter.

Study Population

Three groups of patients were studied. Group I consisted of 11 patients having a silastic ball and cage aortic prosthesis. Ten asymptomatic patients had a S-E #1200 valve inserted in the previous two years. The sounds produced by the S-E #1200 valve were assumed to be quite similar to those of the normally function S-E #1000.⁵ An additional patient with a S-E series #1000 valve inserted six years previously was studied when he developed syncope and peripheral embolization. At reoperation a variant poppet was replaced.

Group II consisted of 10 asymptomatic patients examined within a year of surgery who had a S-E #2310 valve which has a hollow stellite or metal poppet and a velour covered cage. Only the maximal deflection of the clicks, either AO or AC, was measured. One patient with thrombosis of the prosthesis was studied. She was a 54-year-old woman who had an uneventful aortic valve replacement for severe stenosis four weeks previously. Oral anti-coagulation was maintained in the therapeutic range. Upon readmission to the hospital for fever and weakness, cardiac auscultation revealed a grade three out of six systolic ejection murmur at the base and the clicks were difficult to distinguish. She expired as preparations for cardiac surgery were underway. Autopsy showed massive thrombosis within the cage which prevented adequate movement of the poppet.

Group III consisted of one patient each with a S-E mitral prosthesis, a Beall disc mitral valve, Beall tricuspid, and a double prosthesis consisting of a S-E aortic 1210 and a Beall mitral.

Results: Frequency Analysis

Group I: (Figure 2) A plot of decibels against centerband frequency of AO at 4LSB showed a similar contour among the 10 asymptomatic patients although up to 10 dB difference occurred at the higher frequencies. Initial energy averaging 75 dB fell below 30 dB by 1000 Hz. The AO has a higher energy level than AC at the lower frequencies and the ratio of AO to AC changes over the frequency spectrum (Figure 2B). The decibels of AO is higher at 4LSB than AA except at 250 Hz (Figure 2B). The frequency analysis of the AO at 4LSB (Figure 2D) of the patient with BVV compared with a control shows a marked reduction of the sound energy. The complete analysis of the opening and closing click along with the variant prosthetic valve is shown (Figure 3).

Group II: The contour of the frequency analysis of the asymptomatic patients is similar although up to 10 dB difference is recorded. The higher sound

energy level is recorded at 4LSB compared with AA except at 250 Hz. When the clicks emitted by the S-E #2300 valve are compared at 4LSB with those of the S-E 1200, they are similar up to 1000 Hz above which the former prosthesis records the higher energy. This confirms the clinical impression that these stellite valves produce louder clicks than the silastic ones.

Group III: The decibels of the loudest clicks of various prostheses shows a different pattern for each. For instance the Beall disc valve in the mitral position shows a rise in decibels at the higher frequencies and is higher in energy at almost all frequencies at 4LSB than the other prostheses.

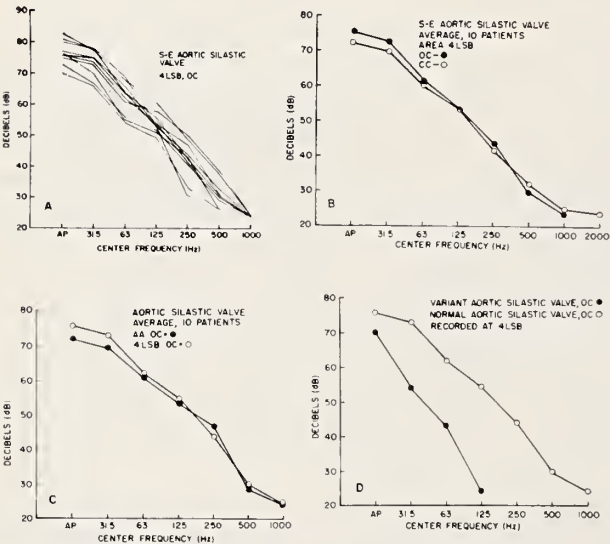


FIGURE 2

(A) A frequency analysis of dB versus Hz of the opening click (OC) of a S-E #1210 valve of 10 asymptomatic patients. (B) The average OC of these patients is compared with the closing click (CC) at 4LSB, the 4th intercostal space at the left sternal border. (C) The average OC at AA, the 2nd intercostal space to the right of the sternum, is compared with OC at 4LSB. (D) The reduced OC of a variant valve is compared with the average OC of patients with normal prosthetic function.

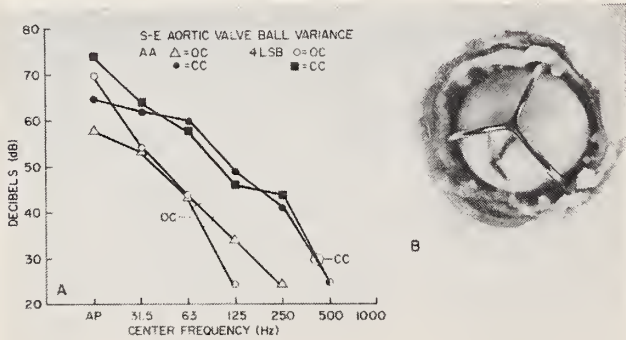


FIGURE 3

(A) The complete frequency analysis of the patient with ball valve variance demonstrates a diminished sound energy of the OC. (B) The silastic poppet from this case shows swelling, cracking, and discoloration.

Peak Frequencies

Group I: (Figure 4) Of the asymptomatic patients with S-E aortic #1200 prosthesis, the average cut off frequency of the AO was seen in eight cases at 1000 Hz and in two at 500 Hz. The patient with BVV had a peak frequency of AO of 125.

Group II: The asymptomatic patients with S-E #2310 valves had a higher cut-off frequency, usually 4000 Hz, with a range of 1000 to 8000 Hz. The thrombotic prosthesis emitted clicks with a cut-off frequency of 250 Hz.

Group III: A Beall mitral, a Beall tricuspid and a S-E silastic mitral prosthesis showed a peak frequency of 16,000, 4,000, and 16,000 Hz respectively.

Oscillographic Record

The pictures of the oscilloscope screen provided a record of the amplitude versus time of the clicks. Timing of cardiac events was facilitated with the electrocardiogram (lead II).

The record of a normally functioning S-E #2310 aortic valve shows that the heart sounds and murmurs persist until 250 Hz above which only the clicks are seen. The clicks are seen to be recorded at a higher frequency at 4LSB than AA. Clicks almost inseparable from the murmur and having little sound energy by 250 Hz were observed in the case of the thrombosed prosthesis (Figure 5).

Discussion

The auscultatory impression of "normal" or "abnormal sounding" clicks cannot be definitely quantitated. The sense of hearing may exaggerate the

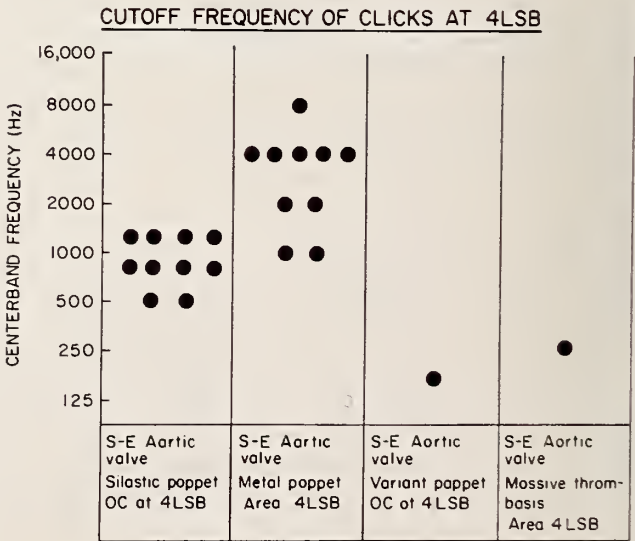


FIGURE 4

The peak or cut-off frequency of the clicks of the patients with normally functioning S-E #1200 and #2310 prosthesis and a variant S-E #1000 and a thrombosed S-E #2310 valve. The last two show greatly depressed frequencies of the clicks.

higher frequency sound, for instance, because of the low threshold in this range. A click or any noise may be more objectively described by the decibel energy level, the frequency spectra and the oscillographic pattern or waveform.

Frequency analysis, a plot of decibel versus frequency, showed a similar pattern when patients with the same model aortic prosthesis were examined. The small differences in the curves were caused by factors altering the emitted sound such as variation in valve size and duration of insertion, chest wall thickness, stroke volume, myocardial contractility and coexisting non-prosthetic heart sounds and murmurs which unavoidably contribute to the total measured sound energy. Despite these many variables only the patients with proven malfunctioning valves had an abnormal test.

Hysten et al.⁴ recorded a diminished ratio of AO to AC amplitude by phonocardiography in 10 of 12 patients with S-E #1000 prostheses proven to be variant. This ratio was greater than 0.5 in 30 of 31 asymptomatic patients. A diminished opening click may be due to softening of the silastic material and subsequent lessened impact during collision of ball against cage. By OBA, the ratio of AO to AC in the same patient depends on the frequency at which it is measured and is not fixed. Six patients with S-E #1000 aortic valves had a ratio of clicks under 0.5 and yet had no evidence of BVV during followup.⁸ In addition, Delman et al.⁹ report false positives for variance in patients with myocardial failure.

Sound spectrography, a system displaying the frequency spectra of sound, has been used to analyze prosthetic heart sounds.⁵ Patients with BVV have a reduced AO averaging 717 Hz at the apex compared with 1117 and 1694 Hz in two groups without variance. The cut-off frequency for distinguishing malfunction was 1300 Hz in 11 of 12 cases. In the patient with variance in the present series of a peak frequency of only 125 Hz of AO was recorded in contrast to the asymptomatic patients whose AO averaged 1000 Hz. These findings may be based on the differences in the sensitivities of the two systems.

One patient with a subsequently demonstrated thrombosed valve showed a marked diminution of AO and AC. It is evident that the clicks were muffled by the thrombotic material interfering with poppet motion. The prosthesis involved, a S-E aortic #2310, was developed to reduce the number of thromboembolic issues. However, an increased tendency for thrombogenesis has been noted in the first few months after insertion, at which time neovascularization is occurring.¹⁰ Octave Band Analysis promises to be effective in the diagnosis of this complication.

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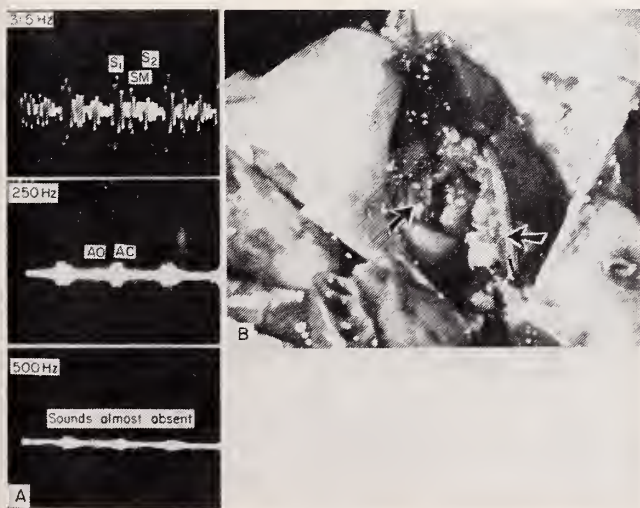


FIGURE 5

(A) The oscillographic record of the patient with thrombosis of a recently implanted S-E #2310 prosthesis shows a reduced sound energy and cut-off frequency. (B) The pathologic specimens from this patient shows thrombotic material (left arrow) obscuring the poppet and sticking to the velour-covered struts (right arrow).

*This paper presents the symptoms,
signs, treatment and a review of 35
patients with the tumor.*

Morton's Neuroma

JAMES W. DEWBERRY, M.D., JOE D. CHRISTIAN, JR., M.D. and
JAMES L. BECTON, M.D., *Charlotte, North Carolina and Augusta*

MORTON'S NEUROMA, or plantar digital neuritis, is a tumor of the foot web space that causes severe symptoms but can be alleviated if a correct diagnosis is made.

All cases at University Hospital in Augusta, Georgia were reviewed for three years (1968-1971). There were 35 patients with 45 operations, of which 43 were primary, two recurrent, and eight bilateral. The anatomical locations were: second web space—three lesions (7.2 per cent); third web space—37 lesions (88 per cent); and fourth web space—two lesions (4.8 per cent) with the location of one lesion not reported. Pathology reports were positive in 43 (96 per cent) cases.

There were 30 females (83.3 per cent) and five males (16.7 per cent) with one recurrent lesion in each sex. The left foot had 27 lesions, and the right foot had 16 lesions, with one recurrent lesion in each foot.

Age distribution was: 1-19 years—two (5.7 per cent); 20-29 years—four (11.4 per cent); 30-39 years—seven (20 per cent); 40-49 years—seven (20 per cent); 50-59 years—12 (34.3 per cent); and 60-69 years—three (8.6 per cent). Results were comparable to those of Kite (Table 1).¹

Anatomy and Pathology

The most commonly affected web space, the third, has its innervation from the median plantar nerve, a branch of the tibial nerve. Rarely a communicating branch of the lateral plantar nerve joins the most lateral branch of the median plantar nerve (Figure 1). This anatomy was aptly described by Morton² in 1876.

The pathology of Morton's neuroma was first described by King³ in 1946 as neural bands of various

sizes separated from surrounding dense connective tissue by a very thick collagenous capsule, represented by a greatly thickened perineuroma. The nucleus of the collagen cells are oval and flat, and the bundles of collagen are laminated, small, and incorporate thick walled arterioles. Another descriptive term is sclerosing neuroma.

The symptoms of this disease are well described by Dr. M. W. Alison according to Kite:¹

My suffering has been beyond all comprehension; very often I have been compelled to jump from my buggy, or stop while walking, remove my boot, which has always been of ample size, apply ligatures to limb or foot, use hypodermic injection of morphine, frictions or call upon someone to assist me by standing on the foot.

Presenting symptoms are classic for this disease. The patient first notes intraweb space numbness and/or pain which is relieved by massage. Some

TABLE 1
CASE COMPARISONS

		Kite	Dewberry
Age	1-19	—	2
	20-29	6	4
	30-39	21	7
	40-49	30	7
	50-59	29	12
	60-69	12	3
	70-	7	—
Space	2nd	11%	7.2%
	3rd	89%	88.0%
	4th	—	4.8%
Sex	Female	96%	83.3%
	Male	4%	16.7%
Foot	Left	53%	63.0%
	Right	37%	37.0%
	Bilateral	15	8

note a grinding or clicking before the onset of the symptoms. Over the next two weeks to four months the numbness progresses to a state of severe pain which may attack the patient at any time but usually when the patient is weight bearing. The patient must immediately remove his shoe and massage his foot to obtain relief.

Mrs. HS (Morton²) says, "The shoe had to be instantly removed, the least delay causing a paroxysm of intense suffering."

Dr. Kite¹ has stated, "I will not accept the diagnosis of neuroma unless the shoe has been removed in public."

Described in History

The first published description of plantar neuralgia appeared in a *Treatise on Corns, Bunions, the Disease of Nails, and the General Management of the Feet* in 1845. Lewis Durlacher, surgeon chiropodist to the Queen, described the condition in his patient, King George IV.⁴

In 1876, T. G. Morton² presented a series of 17 patients with a "peculiar and painful affliction of the fourth metatarsal phalangeal articulation." Morton treated his patients with extra wide shoes incorporating a depression stuffed with padding under the metatarsal heads, followed by removal of the fourth metatarsal head for failure of treatment.

Goldthwait⁵ in 1894 and Robert Jones⁶ in 1897

classified the structural nature of this tumor but made the incorrect conclusion that the pain originated from a prolapse of the metatarsal arch.⁷

Subsequently, treatment evolved along surgical lines with the removal of the neuroma, not the metatarsal heads. Betts,⁸ in 1940, noted the symptoms were caused by a "pronounced neuroma in all cases" and that "neurectomy is simple, rapidly effects a permanent cure and is not so mutilating as removal of the fourth metatarsal head." McElveney⁹ in 1943 advocated the use of the web splitting incision. McKeever¹⁰ in 1952 introduced the ventral approach using blunt dissection and plantar pressure. He also advocated immediate rehabilitation. In 1958 Brahus¹¹ warned against exploration of two web spaces because of the danger of an anesthetic toe. He also suggested a more conservative approach to treatment, i.e., (1) balancing the foot with posterior arches and pads; (2) hydrocortisone injection; (3) surgery if the first two procedures are unsuccessful. The web splitting incision is used most commonly today because of the ease of approach, the decreased danger of an anesthetic toe, and the economy of surgical time. A segment of nerve 2 mm. proximal and distal is removed with the neuroma. This procedure was used exclusively at University Hospital over the last three years.

Diagnosis is made on a careful history and the classic statement of public shoe removal and massage. A simple diagnostic test is to evoke symptoms by pressure on the metatarsal heads. If injection of the web space with a local anesthetic causes relief of pain, a neuroma is likely.

The mechanism of injury is a constant grinding pressure on the interdigital nerve by the metatarsal heads. Many causes have been postulated. The advent of narrow, pointed-toed shoes for females may account for the prevalence of the disease in females. Anyone who must stand or walk while working is more prone to the problem. Trauma plays a major role as a fracture of the metatarsal heads may cause malalignment before remodeling can take place. Morton² described a case (Dr. J. P.) subsequent to a chronic subluxation of the MP joint of the fourth toe.

The results of the surgical procedure are good. Most patients note immediate relief of symptoms. This procedure can be performed under nerve block anesthesia with good results and without the dangers of general anesthesia.

The reasons for recurrence may be the possibility of a doubly innervated web space or incomplete removal of the primary lesion.

The different diagnoses are many (Kite¹). Degenerative and rheumatoid arthritis may cause irritation

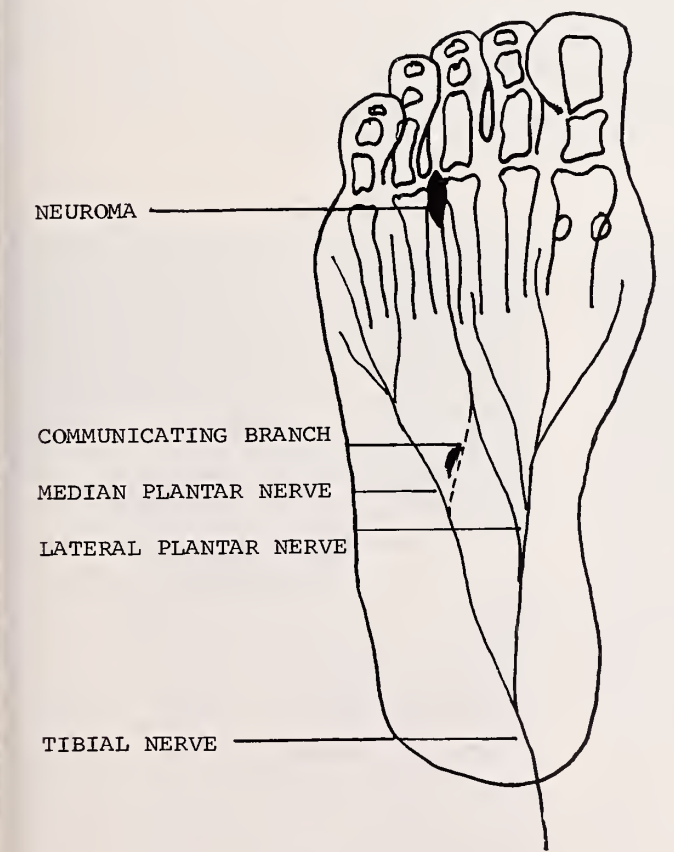


FIGURE 1
Anatomy of Morton's Neuroma

NEUROMA / Dewberry, et al.

and pain but would usually be present with more generalized disease. An atypical location for gout should be ruled out by uric acid determination. Sprains and stress fractures are diagnosed by x-ray, and duration of symptoms. Infections are noted by clinical judgement and joint aspiration. Freiberg's disease and cavernous angioma have also been reported (Berry¹²). Foreign body reaction must also be considered.

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CURRENT CONCEPTS OF CARDIOVASCULAR DISEASE

St. Francis Hospital
Columbus, Georgia

Thursday
October 25, 1973

Guest Faculty:

John Kirklin, M.D., Chairman, Department of Surgery, University of Alabama Medical Center
Mary Allen Engle, M.D., Director, Pediatric Cardiology, Cornell University Medical College
Clark H. Millikan, M.D., Professor of Neurology, Mayo Foundation Graduate School
Thomas Killip, M.D., Professor of Medicine, Cornell University Medical College

Topics:

Recognition and Management of Cardiac Failure in Infancy
Diagnosis of Common Congenital Cardiovascular Disorders
New Horizons in Surgery of Congenital Heart Disease
Surgical Evaluation of Valvular Heart Disease
Diagnosis of Cerebrovascular Occlusive Disease
Prevention of Stroke by Medical and Surgical Means
Evaluation of Surgical Management of Coronary Artery Disease
The Pill and Cardiovascular Disease (not final)

There will be no registration fee and a complimentary luncheon and cocktail party will be provided. Wives are invited as guests of the Muscogee County Medical Auxiliary.

Symposium courtesy Lederle Laboratories Division American Cyanamid Company.

Planned By
THE MUSCOGEE COUNTY AND
THIRD DISTRICT MEDICAL SOCIETIES

EMORY INFORMATION RETRIEVAL SYSTEMS HELP YOU FIND EVERYTHING YOU EVER WANTED TO KNOW ABOUT ANYTHING

Doctors and other health professionals in Georgia can obtain print-outs of references to literature on any medical subject, and copies of the needed literature through Emory's A. W. Calhoun Medical Library, now serving as regional headquarters for the two services.

The first system is known as MEDLINE and involves a computerized bibliographic service which lists, almost instantaneously, titles, authors, source journals, assigned subject headings and other information. Given a desired topic, the system retrieves applicable titles from 400,000 articles in 1,200 health-science journals indexed since January 1, 1969 by Index Medicus. The source journals include those in other languages such as French, German, Russian and Italian.

MEDLINE services are available to the students and faculty of Emory, staff of Emory and Grady Hospitals, and practicing physicians in the Atlanta metropolitan area. For the present, the medical library also will do MEDLINE searches for physicians across the state until more terminals are available at other locations.

Searches are processed by the Reference Department of the Emory medical library (telephone 404 377-2411, extension 7782). Before each search, forms making a request for information must be completed and returned. The forms are available at the library.

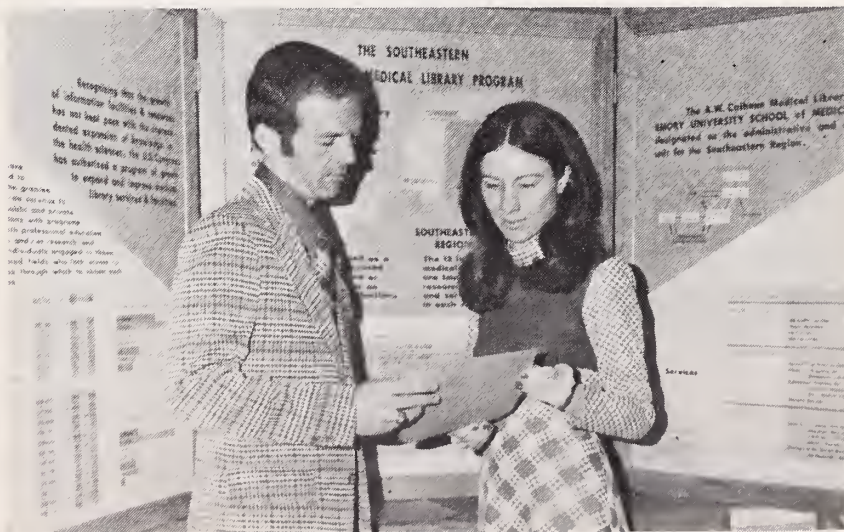
MEDLINE is operated and maintained by the National Library of Medicine and the libraries which serve as terminals are connected through a national time-sharing network to a data base in Bethesda, Md. Access is achieved via telephone lines through teletype, TWX and similar terminals.

MEDLINE is an acronym for MEDLARS On-Line. MEDLARS, in turn, is an acronym for Medical Literature Analysis and Retrieval System.

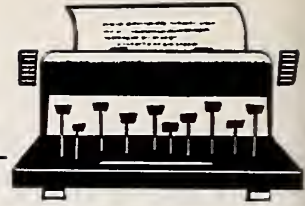
With this list of source references in hand, the physician can seek copies of the journals or books needed through the Southeastern Regional Medical Library Program, an outgrowth of traditional interlibrary loan services provided by medical school libraries.

Requests for this service are made through the institution with which you are affiliated, such as through the medical records librarian at your hospital.

The A. W. Calhoun Medical Library became the headquarters library for the southeastern region in 1969 and serves Alabama, Florida, Georgia, Mississippi, Puerto Rico, South Carolina and Tennessee. The system became operational in 1970 with all medical school libraries in the region agreeing to participate as resource libraries. Journal articles and books are made available either on loan or in the form of photo-copies.



Emory reference librarian Lauren Benevich (L) feeds a medical subject heading via teletype to the Bethesda, Maryland computer which will return a bibliographic list on the topic instantaneously. A second service, which will secure a copy of the needed material through a library exchange system, is explained to MAG field representative Wallie Carpenter (above) by Eloise C. Foster, acting head of the program.



A Doctor Is a Teacher

BY ANY DEFINITION, be it Webster's or from any source, a doctor is a teacher—a learned man.

We as a profession are being herded more and more like voiceless sheep into a corner by government functionaries who are openly questioning our competence to continue doing the job for which we have been trained. Every facet of our profession is being challenged by many; in our legislative assemblies and in such grass root forums as social gatherings. We in the medical profession have the capability to reverse this tide of negativism toward our mode of delivery of health care to ill patients.

A pertinent question comes to mind—are we, in our well-meaning desire to treat successfully an optimal number of patients, overlooking our overriding responsibility to inform not only our patients but the general public in matters regarding the prevention of disease?

Rising Mortality Rates

We hear over and over of the “health care crisis.” Billions of dollars have been spent through public and private programs in an effort to alleviate the “crisis,” apparently without much success. In spite of all our technological advances in the field of cardiology and cardiovascular disease, mortality from heart disease continues to climb. Even though great advances have been made in the recognition and treatment of many respiratory diseases, mortality rates are rising. This retrogression in the national health—at least for men—has occurred at precisely the period when almost every available input index of health care progress has been rising. Death is, of course, the ultimate in poor health. It is also the best reported. But death is only the visible part of an iceberg. For every middle-aged man who dies of lung carcinoma, how many top flight executives are there who really know what they need to know about coronary risk factors?

The science writers and political functionaries are not the ones who know the answers to lowering our death rates through disease prevention. We, by virtue of our training and our day-to-day contact with patients who develop diseases are uniquely qualified to teach a receptive population how to go about attacking disease through prevention rather than waiting for its full-blown development.

Why should not we who have this knowledge of the causes of increasing disease rates inaugurate a well-thought-out program of education for disease prevention and make it available to all who seek it in the hope that they will help us disseminate this knowledge. We have the manpower and the resources to do it. No one else can do it.

Few of us, with our large patient loads, can devote more time to education of patients during our regular office schedule. Our office waiting rooms can be a prime starting point for patient education. There are numerous well-written leaflets which are admirably suited for patient education. These may be purchased for distribution or, better still, they could be written by ourselves and reproduced for patient distribution. Many doctors already are recognizing the teaching value of audiovisual

equipment in their waiting rooms. A physician's office can indeed be a health education center rather than a repository for out of date magazines.

Public Forums

About 15 years ago, some county medical societies presented a few public forums on subjects relating to health. Most of them attracted standing-room-only audiences and were very well received. It would not constitute a burden to any medical society to staff a continuing program of health-oriented forums open to the public at no cost. The public is hungry for authoritative preventive health care information. We, the doctors, are the ones qualified to give it to them. We are trained to be teachers, we have the knowledge and we have a population whose needs and desires are ripe for such a program. If we could successfully initiate and sustain such a program of public service, what a great boon it could be to the health of our nation. What an immediate bridge of understanding could be created by such a spontaneous program of health education initiated by our profession.

Even in those communities where only one or two doctors are available, it could still be most helpful to schedule a one- or two-doctor health forum. These could be scheduled every four to eight weeks for an hour in a public gathering place where seating would not be limited. Not only could the health of the community be upgraded by such open forums, but the percentage of phone calls and night calls could be lowered substantially by a public better informed in matters regarding their health.

These are measures that we can take right now. They need no legislative action. They need no huge budgets. How better can we serve the public interest and at the same time fulfill our responsibility as teachers of medicine.

E.W.

HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

April 15, 1973

Appointments: Mr. J. Winston Huff, Atlanta, to MAG Benevolent Foundation Board of Trustees; Walker C. McGraw, Atlanta, to Occupational Health Committee; John Mauldin, M.D., Atlanta, Charles Underwood, M.D., Marietta, Judson Hawk, M.D., Atlanta, Gerald Zwerin, M.D., Atlanta, William Logan, M.D., Atlanta, Duane Blair, M.D., Decatur, William Barron, M.D., Newnan, Fleming Jolley, M.D., Atlanta to Task Force on Newborn Coverage in Health Insurance.

Regional Medical Program: Received report on federal approval of GRMP phase out scheduled for completion by February 14, 1974.

PSRO: Discussed statewide and local PSRO structure for state. Suggested meeting of representatives from major medical trade areas to meet during Annual Session to discuss geographical areas of PSRO's in

Georgia. Authorized legal counsel to incorporate new organization that could qualify as PSRO.

EMCRO: Received report on imminent announcement of federal funding for MAG Health Statistics System. Heard described Hospital Abstract System testing program for summer of '73 and current testing phase of Nursing Home abstract.

MAG Member Insurance Program: Reviewed detailed report suggesting possible coverages. Authorized bringing report to attention of Insurance Committee requesting their recommendation.

AMA Survey Report: Heard team report, deferred action to May Executive Committee meeting.

Medical Disciplinary Board: Heard report from Ad Hoc Committee to Study Medical Disciplinary Boards of plan to request House of Delegates authorization to establish a "Medical Investigating Committee" to be an arm of the Board of Medical Examiners.



KEEPING UP—GETTING AHEAD

I AM GRATEFUL to the members of the Medical Association of Georgia for electing me President of the Association. It is a great honor!

I pledge a sincere effort to do a good job and with the assistance, tolerance and cooperation of the members, the Delegates, Council, Executive Committee and Headquarters staff, I feel that I will be capable of keeping abreast of the problems that will confront us during the year.

I have served on Council and the Executive Committee since 1959 and I can assure you that the greatest single problem facing the physicians of Georgia and the United States is the very simple fact that about half of us will not expend the effort necessary to keep up with what is going on at MAG in Atlanta or at AMA in Chicago; in the Georgia General Assembly or the United States Congress.

MAG's House of Delegates often enacts legislation that is promptly published in our *Journal* and the Delegates to the Annual Session take their handbooks home and, hopefully, report the proceedings to the local membership. Invariably, in three, six, or nine months, officers of the Association or Council will be subjected to criticism by a member or members who simply have not been to local society meetings or read MAG mail or the *Journal*. A member who can offer knowledgeable, constructive criticism is always welcome. We need this type of criticism, but criticism born of ignorance is another matter and can result only in a waste of valuable time.

I urge you—please read the *Journal* and letters mailed to you from the Medical Association of Georgia. Become involved in organized medicine and keep abreast of MAG and AMA activities. Then let us know your feelings. Remember, we of the Council and Executive Committee and the Headquarters are tending to *your* business!

Again, I solicit your support and cooperation during the coming year. The MAG is at this time one of the better and more progressive state associations and, with your support, I will attempt to keep it strong and active.

I am honored and will do my best for you individually and collectively. I invite any physician, member of MAG or not, to contact me or the MAG Headquarters staff if and when we can serve you.

A cursive handwritten signature in dark ink, reading "Charles E. Bohler, M.D.".

Charles Emory Bohler, M.D.
President, Medical Association of Georgia



MAMMOGRAPHY, XEROGRAPHY AND THERMOGRAPHY OF THE BREAST

ROBERT L. EGAN, M.D.,* *Atlanta*

TODAY IN MANY BREAST CLINICS the decision to biopsy or not to biopsy the breast is preceded by mammography. This is the practice as well for aspiration of a cyst or any other treatment of the breast. This policy has evolved through routine use of mammography with good radiographic detail.

In other clinics x-ray studies of the breast are never done even with a strong clinical suspicion of cancer. This continues as a result of the lack of awareness of the value of the procedure or previous exposures to disastrously poor mammography. Varied levels of the use of radiography of the breast exists between these extreme philosophies.

Radiologist's Responsibilities

With good mammography the radiologist is often projected into the center of many activities of the care of the patient. He must decide in many instances whether to biopsy, what to biopsy and just precisely which tissue to be studied under the microscope. At times he must check by x-raying the blocks and residual biopsy specimens that maximum efforts have been made toward the proper diagnosis. Sub-optimal mammography demonstrates only what is so obvious clinically that treatment of breast diseases is a monotonous routine.

At Emory efforts have been continued to instruct radiologists in mammography. During the past year, 45 radiologists and 89 x-ray technologists have been trained in mammographic techniques and interpretation for thorough indoctrination before it is instituted by them. The simplicity of the technique, requiring no special radiographic equipment or abilities, is an inherent fault in impressing upon radiologists that precise attention to the technique is required to produce mammograms of acceptable detail. The plea is not to discourage the use of mammography, as it shows unlimited promise, but to encourage a sensible application as a supplementary diagnostic procedure.

Best Screening Procedure

Mammography has proved to be perhaps the best procedure for screening segments of the population for human cancer. The cost of screening for breast cancer on a national scale is not prohibitive but presently the lack of adequately trained professional allied health personnel is prohibitive. In the next few years there will be jointly sponsored by the American Cancer Society and the National Cancer Institute 20 centers in the United States with each screening 5,000 asymptomatic women per year for breast cancer. There is great need to identify classes of patients

* Chief, Mammography Section, Emory University.

with a high likelihood of being early breast cancer patients by history, physical examination, thermography and other available means. Then by concentrating use of mammography on these groups all women in the United States over age 40 could have reasonable access to this worthwhile procedure.

Mammography continues to stimulate interest in other means of detecting earlier breast cancers such as xeroradiography and thermography which hopefully will increase our ability to care for the breast cancer patient.

Xeroradiography is another method of doing mammography and differs only that the radiographic image is captured on paper by a dry process. Equipment has not been available long enough for evaluation of this procedure. At Emory it has been used one year.

Thermography is a sensitive method of recording skin temperatures often elevated over the breast when cancer is present. Used alone a high percentage of cancers are missed; many benign conditions produce increased skin temperatures. It could be very useful when combined with other diagnostic procedures to identify high risk breast cancer patients.

Mammography can be learned well in a short period (five days). It is simple yet invaluable. It can be readily adapted to longitudinal studies for determination of precursors of breast cancer, treatment planning and prognosis for breast cancer. The future utilization of mammography is not so much confined to the woman with a breast lump but in asymptomatic women with a high likelihood of having a very early breast cancer or of getting a breast cancer.

*Emory University
1365 Clifton Road 30322*

TECH-EMORY WALKING LABORATORY DESIGNED TO HELP THE DISABLED

Dr. Morris Milner, a bioengineer from South Africa, is establishing a human locomotion laboratory to measure the attributes of walking during a one-year joint appointment as a visiting professor at Georgia Tech and Emory University.

Dr. Milner is working with the Georgia Tech School of Electrical Engineering and the Emory Physical Medicine Department's Rehabilitation, Research, and Training Center.

The laboratory is being built in Tech's Van Leer Electrical Engineering Building, because it has sufficient space in which to conduct the extensive series of studies Dr. Milner has planned.

He will study the normal actions of walking to help devise ways and programs to correct the compromised

walks of those suffering from paralysis or accidental disabilities. The walkway facilities lab will also be used to evaluate corrective devices. Both prosthetic (replacement parts) and orthotic (functional replacement) devices will be studied.

Among the more intriguing experiments he plans are those related to programmed electrical stimulation of muscle. As an example, an electrical instrument strapped to the waist of a stroke patient would, on activation of a switch in the shoe, trigger a signal to replace the paralyzed neuro-muscular action necessary to lift the toes and foot.

This would enable the patient to take a normal stride, rather than having to drag his paralyzed leg.



OUTPATIENT GYM EXERCISE FOR PATIENTS WITH RECENT MYOCARDIAL INFARCTION

GERALD F. FLETCHER, M.D. and JOHN D. CANTWELL, M.D.,* *Atlanta*

THE BENEFIT OF ORGANIZED physical activity to patients with recent myocardial infarction has been recognized in studies from several countries particularly in Scandinavia, Germany and Israel. One reason why organized exercise programs are valuable is that heart rate and blood pressure (as determinants of heart work) decrease in normal subjects and in cardiac patients who have been physically trained.

Eligibility for exercise training in patients with recent (10 to 12 weeks) myocardial infarction is dictated in part by the absence of complications. Persistent heart failure, recurrent disabling arrhythmias, refractory angina pectoris or severe hypertension are factors which should exclude patients from such programs. Patients with these complications frequently fail to respond favorably to training and may exhibit hemodynamic deterioration. Eligibility should entail permission from the patient's personal referring physician. Baseline testing in a patient with recent myocardial infarction should be performed with a submaximal exercise work load (preferably on a treadmill) of 75 to 80 per cent of the patient's predicted maximum. This type of exercise testing is safe and useful in determining the level of exercise to be prescribed. At the time of testing a subjective and objective cardiovascular data base including the baseline electrocardiogram are obtained and oxygen consumption is measured with the patient at rest and during exercise. The changes in oxygen consumption observed can be used to estimate the patient's cardiopulmonary efficiency for a given work load.

Exercise training can be performed in numerous facilities. YMCA's, gymnasiums, community recreational centers and outdoor exercise areas serve well. For our purposes utilization of the air cooled, air heated hospital gymnasium has been quite effective.

Carefully Monitored Exercise Sessions

Our program at Georgia Baptist Hospital is similar to others. Exercise classes are held three times weekly and each session is divided into a 15 minute period each of walk-jog sequence, calisthenics, and team sports. The level of exercise for each patient is prescribed by the program director on the basis of the initial work load achieved in testing and subsequent progress. Other considerations are blood pressure and S-T segment responses on radio electrocardiography during exercise. At each session the nurse or technologist records the patient's resting blood pressure and talks with the patient regarding physical or emotional changes that have transpired during the day. The patient himself then measures and records his heart rate before and after each 15 minute period of exercise.

A physician and either a physician's assistant, nurse or technologist are in attendance during all exercise sessions. They frequently exercise with the patients. To

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association. Dr. Fletcher is director of internal medicine at Georgia Baptist Hospital and associate professor of Medicine at Emory University School of Medicine. Dr. Cantwell serves as associate director of cardiac rehabilitation for Georgia Baptist Hospital.

assist the medical personnel, closed circuit television monitoring is utilized from the swimming pool, ping-pong and volleyball areas with a central receiving set in the gymnasium office. Cardiac resuscitation equipment and cardioactive drugs are available and a litter and a wheelchair are available for immediate transport of patients to the hospital emergency room should the need arise.

At the end of each three month period the patient's personal physician receives a written progress report. After six months our subjects are given the option of continuing the program or performing their exercise prescription on an individual basis at a local YMCA or in a medically approved neighborhood exercise program.

Outlook Improves for Patients

During the first 18 months of our program, 42 patients have completed three or more months of training. Of the 42 patients, 33 had increases of three to eight minutes in follow-up treadmill exercise test time. The exercise quotient (maximal exercise heart rate times the maximal exercise systolic blood pressure divided by the submaximal treadmill exercise test time in minutes or $\frac{HR \times SBP}{STET}$) decreased in all but one of the patients. Two of three patients who initially had electrocardiographic signs of ischemic heart disease now have normal electrocardiograms with exercise. An "esprit de corps" has developed in these patients which appears to facilitate acceptance of their disease and whatever limitations it imposes upon them. Thirty-eight of the 42 patients (90 per cent) are gainfully employed.

Coronary atherosclerotic disease is becoming more manifest in this country each year. Considerable evidence in the United States as well as other countries suggest that proper exercise can modify several coronary risk factors such as blood pressure, serum triglycerides and cholesterol, body weight and emotional tension. Although no control group has been evaluated, our experience, as well as that of others, suggests that as long as exercise is done with careful supervision it is safe and seems to be beneficial in the management of patients with recent myocardial infarction. Baseline and follow-up testing are not difficult and the program is enjoyable. As more data become available, it is likely that this type of therapy will find an increasing role in the management of such patients.

300 Boulevard, N.E. 30312

YEAR-OLD GASTROENTEROLOGIC SOCIETY WELCOMES NEW MEMBERS

The Georgia Gastroenterologic Society, formed early in 1972 to promote the knowledge of and share common problems in the field of gastroenterology, is now opening membership to all physicians and health scientists.

The current membership includes some 60 internists, gastroenterologists, radiologists, pediatricians, pathologists and surgeons. Officers are James Achord, M.D. of Macon, president; Julius Wenger, M.D. of Atlanta, vice president; and David Taylor, M.D. of Atlanta,

secretary-treasurer.

Two statewide meetings were held in 1972: an initial meeting in Macon in the spring and a weekend meeting at St. Simon's Island in September. An additional open meeting with a professional program is scheduled for September 29-30, 1973 at the King and Prince Hotel on St. Simon's Island.

For additional information, contact Dr. Taylor at 340 Boulevard, N.E., Atlanta 30312; or Dr. Achord at 777 Hemlock Street, Macon 31201.



INFORMED CONSENT

JERRY B. BLACKSTOCK,* *Atlanta*

LAWSUITS AGAINST PHYSICIANS charging a failure adequately to disclose the risks and alternatives of proposed treatment are not innovations in American law. Such lawsuits date back at least a half century, but in the last few years they have multiplied rapidly. The term "informed consent" is used today to refer to the doctrine that a consent effective as authority to treat can arise only from the patient's understanding of alternatives to and risks of the treatment.

Although the Georgia Appellate Courts have stated that a physician or surgeon has a duty to disclose or warn of the hazards of a correct and proper procedure of diagnosis or treatment,¹ the Georgia Courts have not clearly stated any guidelines for the extent of disclosure by a physician in the context of informed medical consent.

Right of Self-Determination

Courts in other states, however, are increasingly recognizing and setting standards to protect the patient's right of self-determination for non-emergency medical care. These courts set forth the position that even when a thorough investigation is conducted, and proper expert judgment is exercised in deciding that a proposed procedure is actually needed, the patient has the right to be informed and to appraise the possible benefits and risks in order to render a valid consent.

Two recent cases in other states have attempted to define the extent of disclosure required of a physician in order to obtain an informed consent.²

The United States Court of Appeals for the District of Columbia³ was faced with a factual situation where a young man troubled by back pain agreed to undergo a laminectomy. After the operation, the patient progressed well until he fell while unattended after which his condition deteriorated with the result of partial paralysis. The question presented was whether a one per cent possibility of paralysis resulting from a laminectomy was peril of sufficient magnitude to bring a disclosure duty on the part of the surgeon into play.

The Washington Court made it clear that the duty does not depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the patient. The Court likewise "discarded the thought" that the patient should ask for information before the physician is required to disclose. The Court said "Caveat Emptor (buyer beware) is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions; it is a duty to volunteer, if necessary, the information that the patient needs for intelligent decision."

Nebulous Standards

In determining the extent of the disclosure, the general standard set by the Court is a nebulous one; the standard measuring performance of that duty by physicians

* Prepared at the request of The Medical Association of Georgia. Mr. Blackstock is an associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association.

is conduct which is reasonable under the circumstances. A risk is material, the Court stated, when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.

The Washington decision then adopts a negative approach and states that a physician has no obligation to communicate those dangers of which persons of average sophistication are aware. The Court gives as an example infection, a danger inherent in any operation. The physician likewise bears no responsibility for a discussion of hazards the patient has already discovered. The Court goes on to state that another exception to the rule that a physician must disclose the risks of a procedure is in the case of emergencies (however the Court cautions that even in situations of that character the physician should attempt to secure a relative's consent if possible).

The Court discusses a generally recognized exception where the risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. The Court cautions that the physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, and even in a situation of that kind, disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alternative open to the physician.

A recent California case⁴ involved a patient who underwent surgery for a very small but active duodenal ulcer. During the course of the operation, an artery was severed necessitating the removal of the spleen in a second operation. A gastric ulcer later developed and a third operation, a hemigastrectomy, was performed.

In discussing the issue of informed consent, the California Court said that the physician had a duty of reasonable disclosure of the available choices with respect to proposed treatment and the dangers inherently and potentially involved in each. In defining what the Court considered reasonable, a mini-course in medical science was not required because the patient is concerned primarily with the risk of death or bodily harm, and problems of recuperation. Relatively minor or very remote risks inherent in common procedures need not be mentioned. An example given by the Court was the administration of antibiotics.

Case for Nondisclosure

The California Court stated that the physician has a greater duty when complicated procedures are involved. In these situations, the physician must disclose the potential of death or serious harm, and explain in lay terms the complications that might possibly occur. Several exceptions to this broad general rule were found acceptable by the California Court. Disclosure of risks need not be made if the patient requests that he not be so informed or if the procedure is simple and the danger commonly known to be remote. The Court also noted the exceptions that a physician need not disclose the risks of a procedure in the case of an emergency or in the case of an incompetent patient (such as a minor) when the consent of the parent or guardian is sufficient.

The California Court did acknowledge the necessity in some cases for nondisclosure if a disclosure would so seriously upset the patient as to make him unable to weigh the risks dispassionately. The Court pointed out that the last mentioned exception appeared to be most often relied upon by physicians in defending malpractice cases. The Court cautioned that this reliance often was not well placed because the burden was on the physician to prove that for the particular patient a disclosure of some specific risk would preclude the dispassionate evaluation in the patient's consent.

The important points to keep in mind thus appear to be that if a particular pro-

cedure is associated with a risk of death or serious harm to the patient, he should be informed of this risk. Moreover, the peculiar risks associated with a specific procedure should be disclosed. If a procedure is new, experimental or extremely hazardous, the physician has a greater duty of disclosure of risks. Where a procedure is purely elective or cosmetic, the physician should be aware that he has a greater duty to disclose possible risks.

Keep Notes on Disclosures

It is unwise for the physician to rely upon nurses, hospital personnel or assistants to make the necessary disclosures to the patient to insure his informed consent. As a practical matter, the physician who discusses the potential risks with a patient should make a note of the discussion either in the hospital progress notes or in the physician's office notes with specific references to the disclosures made. These notes when entered at the time of the discussion or shortly after the discussion are effective in later proving both the fact and the extent of the disclosure. Several years after the procedure when a witness is called upon to testify concerning the disclosure, his memory may be faded or vague; the hospital progress notes or the office notes will not have changed.

The root premise of informed consent is the fundamental concept that every human being of adult years and sound mind has a right to determine what shall be done with his own body. True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these considerations the trend in the courts today is to fix the requirement of a reasonable divulgence by the physician to the patient in order to make such a decision possible.

This area of medical law is changing rapidly and all physicians should be aware that their communications with their patients are coming under increasing scrutiny by the courts.

*Eleventh Floor
C & S National Bank Building 30303*

REFERENCES

1. *Mull v. Emory University, Inc.*, 114 Ga. App. 63, 140 S.E.2d 276 (1966).
2. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 502 P.2d 1 (1972); *Canterbury v. Spence*, 464 F.2d 772 (D.C.Cir. 1972).
3. *Canterbury v. Spence*, *supra*.
4. *Cobbs v. Grant*, *supra*.

FORMER ATLANTAN NAMED EDITOR OF HEART PUBLICATION

Eugene A. Stead, Jr., M.D., professor of medicine at Duke University in Durham, N.C., has been named editor of *Circulation* beginning with the July 1973 issue of the American Heart Association's monthly scientific journal. He succeeds the late Charles K. Friedberg, M.D.

A native of Atlanta, Dr. Stead received his B.S. degree in 1928 and his M.D. in 1932 at Emory University. He was named Chairman of the Department of Medicine at Emory in 1942, and Dean in 1945. Dr. Stead was Professor of Medicine and Chairman of the Department of Medicine at Duke University from 1949

to 1967 when he became Florence McAlister Professor. He also holds the title of Distinguished Professor.

Active in work of the American Heart Association for many years, Dr. Stead has served on its Board of Directors, its Research Committee, Scientific Council and as Chairman of the Ethics Committee. He has been a member of the Editorial Boards of *Circulation* and *Circulation Research*. He has received AHA's Citation for Distinguished Service to Research and in 1970 the American Heart Association awarded Dr. Stead the James B. Herrick Award for outstanding achievement in the advancement and practice of clinical cardiology.

SYSTEM OF FINANCE REPORTING OF THE MEDICAL ASSOCIATION OF GEORGIA

A "Summary Comparison of Budgeted and Actual Operations" is prepared monthly for the Treasurer to present to the Executive Committee of Council and the Council.

As the budget is presented annually in the *Journal of the Medical Association of Georgia*, this explanation of the Finance Report will give a summary of income and expenditures followed by a detailed breakdown in explanation of the summary.

INCOME: (The sources from which the funds of the Association come.)

- I. (a) Dues
- (b) Interest earned and miscellaneous income
- (c) Family Physician services
- (d) Parking
- II. Annual Session
- III. *Journal* advertising and subscription sales
- IV. Contingent (Transfer from Operating Unrestricted Funds for costs not covered by above income items)

EXPENSES AND COSTS:

- I. (a) Fixed allotments (These are expenses and costs, including mortgage payments, that occur annually and remain reasonably consistent)
- (b) Association office less reimbursable* expense (These expenses are recurring, but are subject to change and rise and fall on a cost or market basis)
- (c) Association committees (These are the selective activity group costs that allow service and education to the general public and Association members)
- (d) Related activities costs (Costs incurred at both AMA meetings and aid to SAMA and SMEB)
- (e) Executive Committee discretionary fund (Amount set apart for the Executive Committee to spend as needs arise)
- (f) Contingent expense (Amount spent only by Council for necessary items either not budgeted or budgeted items that exceed amount set by Finance Committee)
- II. *Journal* expense (All *Journal* expenses including the Roster and Woman's Auxiliary Roster)

LIQUID FUNDS AVAILABLE: (Association cash, both in checking account and invested in securities at highest yield available)

(*) **REIMBURSABLE EXPENSE:** This is the most

difficult item in the budget either to explain or understand. These reimbursements are received from outside contracts or grants administered by the Association and usually housed in the Association building. They are a return of the monies spent by the Association for budgeted items useful and beneficial both to the Association and the outside contracts (GRMP, CHAMPUS, EMCRO, etc.) and a negotiated method is used in the determination of each group's portion of these costs. Since these costs cannot be charged directly to an outside contract or the Association, they are referred to as "Indirect Costs."

Thus, the following, which is the negotiated method referred to above:

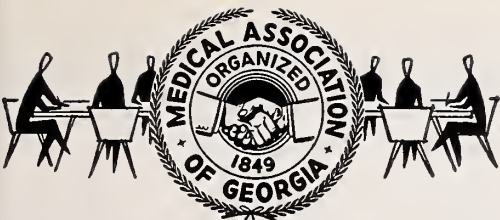
INDIRECT COST POOL: (Those expenses not directly chargeable)

1. Salary of the Executive Director of the Association (**)
2. Salary of the Assistant Director, Finance (**)
3. Depreciation
4. Property taxes
5. Officer honoraria (**)
6. Janitor supplies and service
7. Utilities
8. Building maintenance
9. Equipment maintenance
10. Insurance
11. Audit fees
12. Legal retainer
13. Fringe benefits for employees listed in items 1, 2 and 5
14. Total of all of above expense items

Next, it is necessary to total all salaries of all groups having occupancy in the Association building and sharing expenses listed in the Indirect Cost Pool, as follows: (Example)

	Salaries Total	Minus Salaries Indirect	=	Salaries Direct
MAG	\$100,000	\$30,000 (**)		\$ 70,000
GRMP	250,000			250,000
CHAMPUS	50,000			50,000
EMCRO	50,000			50,000
TOTAL	\$450,000	\$30,000		\$420,000

The Total Salaries Direct is now divided into the Total of the Indirect Cost Pool. This gives the percentage of Indirect Costs for each contract. This percentage of the direct salaries of each contract is the amount of reimbursable expense the Association receives.



THE ASSOCIATION

NEW MEMBERS

Adams, John W., Jr. Active—W-C-D—Path	TRI-County Hospital Ft. Oglethorpe, Georgia 30741
Asbell, Jimmy R. Active—Bibb—Or	761 Hemlock Street Macon, Georgia 31201
Altvater, Arnold H. Active—Ga. Medical— Path	11705 Mercy Blvd. Savannah, Georgia 31406
Alvarez, H. W. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31061
Baskin, Henry J. Active—Troup—I	303 Smith Street LaGrange, Georgia 30240
Bransome, Edwin D., Jr. Active—Richmond—I	Medical College of Georgia Augusta, Georgia 30902
Carbaugh, Robert G. Active—Ware—Anes	1921 Alice Street Waycross, Georgia 31501
Castro, A. E. Active—W-C-D—FP	504 Thomas Road Ft. Oglethorpe, Georgia 30741
Collins, Myron D. F. Active—Richmond—Or	1421 Gwinnett Street Augusta, Georgia 30902
Dulock, Malcolm P. Active—MAA—FP	1000 S. Buford Highway Norcross, Georgia 30071
Gonzalez, Edward A. Active—F-P-C—OBG	206 Hospital Circle Rome, Georgia 30161
Hancock, Carl V., Jr. Active—Dougherty—U	1108 N. Jefferson Albany, Georgia 31705
Harper, Charles R. Active—MAA—AM	P. O. Box 20787 Atlanta, Georgia 30320
Hartlage, Patricia L. Active—Richmond—Or	Medical College of Georgia Augusta, Georgia 30902
Levy, Charles E. Active—MAA—P	3400 Peachtree Rd., N. E. Atlanta, Georgia 30326
Luxenberg, Malcolm N. Active—Richmond—Or	1120 15th Street Augusta, Georgia 30902
Marcus, Robert D. Active—Muscogee—OTO	1962 North Avenue Columbus, Georgia 31901
Mitchell, Marvin M. Active—Cobb—Or	1620 Mulkey Road Austell, Georgia 30001
Moore, Charles R. Active—Colquitt—Oph	1303 Fourth St., S. W. Moultrie, Georgia 31768
Pritzker, Martin S. Active—Ga. Medical—D	P. O. Box 13603 Savannah, Georgia 31406

Quantz, Newton G., Jr. Active—Richmond—Oto	1021 15th St. Augusta, Georgia 30901
Roque, R. T. Active—Ga. Medical—FP	Springfield Medical Profes- sional Springfield, Georgia 31329
Self, Stanley J. Active—F-P-C—D	302 W. 6th Street Rome, Georgia 30161
Vanderzalm, Theodora Active—DeKalb—R	1364 Clifton Rd., N. E. Atlanta, Georgia 30322
Wilkes, Leslie L. Active—Ga. Medical—Or	44 Medical Arts Savannah, Georgia 31405

PERSONALS

First District

Claxton and Evans County residents observed March 25 as "Dr. Curtis G. Hames Day" in recognition of the physician's contributions to the medical profession. Dr. Hames received national attention for his findings in an NIH sponsored study of coronary heart disease in Claxton. As president of the Georgia Heart Association, he now directs its policies and helps supervise its 14 clinics throughout the state.

Second District

William D. Potter has moved his practice from Ellaville to Camilla, effective March 15, 1973.

Third District

Thomas M. Adams and **J. Fred Adams**, who have operated the 45-bed Macon County Clinic since 1935, have closed the doors of that Montezuma health facility following the retirement of "Dr. Fred." MAG recognized the doctor in 1971 for "50 years of proficient and untiring ministry of the science of healing." His partner will continue to see patients in the clinic's office.

Buena Vista's **W. M. Calhoun** has begun part time service in Ellaville.

Charlie McArthur, Camilla, was honored by the Kiwanis Club in March for "41 years of devoted service to his community through his work in Kiwanis."

Jose Carlos Serrato, Columbus, has been appointed Honorary Consul for Mexico replacing Clifford M. Clarke. The Mexican native, now a U.S. citizen, has served for the past 10 years as Georgia delegate for the National Tourist Council of Mexico and is the former cultural attaché to the Honorary Consulate of Mexico in Atlanta, member of the World Trade Council of the Atlanta Chamber of Commerce and serves on the Executive Committee of the Democratic Party of Georgia.

Fifth District

Seven faculty members in the department of gynecology

ASSOCIATION / Continued

cology-obstetrics of Emory University School of Medicine have been promoted to full professor: **Malcolm G. Freeman**, **Armond E. Hendee**, **Luella Klein**, **William M. Lester**, **Zuher Naib** (member of the DeKalb County Medical Society), **Samuel Poliakoff** and **John H. Ridley**.

Edward G. Bowen, Atlanta, has opened a Roswell office for the practice of obstetrics and gynecology. Dr. Bowen is incorporated as Perimeter North Gynecology and Obstetrics.

At a recent meeting of the Southern Medical Association in New Orleans, **John M. Roberts**, Atlanta, was elected secretary of the Orthopaedic Section and **Samuel B. Chyatte** was elected chairman of the section on physical medicine and rehabilitation. In addition, Dr. Roberts has been appointed editor of *Selected Bibliography of Orthopaedic Surgery* published by the American Academy of Orthopaedic Surgery. **Richard D. Carr** has been elected secretary-elect of the section on physical medicine and rehabilitation of SMA.

Presiding over the annual meeting of the American College of Allergists, held in Atlanta April 7-10, was **Lamar Peacock**, outgoing president of the organization. The meeting, which included a three-day post-graduate seminar, attracted 1,000 visitors nationwide. **Sawyer Eisenstadt** of Minneapolis, Minn. was installed as the new president, and **John Leonardy** of Atlanta began service on the organization's governing Board of Regents.

F. James Funk is president-elect of the Georgia Chapter of the Arthritis Foundation and in January aided the U.S. Women's Ski Team as team physician.

Daniel D. Hankey, Atlanta, specialist in internal medicine, has been elected to the Board of Directors of The National Bank of Georgia. Dr. Hankey is also a member of the Atlanta Chamber of Commerce and the Board of Directors of the Arthritis Foundation of Georgia.

Drs. J. Willis Hurst, **Robert C. Schlant**, **W. Dallas Hall, Jr.** and **H. Kenneth Walker** made up an Emory team that won the first place Governor's Award for the scientific exhibit judged outstanding at the February 22nd Scientific Session of The American College of Cardiology in San Francisco.

Seventh District

Marietta's **Benjamin H. Wofford** authored an article, "Treatment of High Velocity Paint Gun Injury of the Hand," which was published in the March issue of the *Southern Medical Journal*.

Eighth District

Eugene D. Bell, Douglas, was chosen by the nursing personnel of Coffee General Hospital as Doctor of the Year for 1972 for his professional attitude, courteous attitude and medical helpfulness.

Tenth District

Thirty-one years after becoming the first female physician in Athens, **Loree Florence** has been selected

1972 Woman of the Year Golden Award winner by the Athens Business and Professional Woman and the First American Bank and Trust Co. In 1921 she entered the Medical College of Georgia as its first female student and graduated second academically in her class.

An MCG professor of endocrinology, **Robert B. Greenblatt**, has been nominated to the rank of Chevalier of the National Order of the Legion of Honor by the French Republic in recognition of his "efforts toward the understanding and cooperation between our two countries." An essay published by Dr. Greenblatt in 1971 offered a new diagnosis for the causes of the death of Napoleon, that of an intractable gastric ulcer and multiple endocrine tumors.

DEATHS

DeWitt Frank Mullins

Augusta pathologist DeWitt Frank Mullins, Jr. died February 2, 1973 in a plane crash.

The Canton native was graduated from Emory University School of Medicine and served as assistant resident in pathology at Grady Memorial Hospital. He was resident in pathology in the Jackson, Miss. Foster General Hospital, later serving in the U.S. Army Medical Corps at the close of World War II.

Dr. Mullins had been in practice in Augusta since 1952 and was clinical professor in pathology at the Medical College of Georgia; professor of bacteriology and veterinary hygiene with the University of Georgia School of Veterinary Medicine; and chief of laboratory service, Finney General Hospital, Thomasville. In the past, he had served in various capacities with Emory University, Milledgeville State Hospital and Louisiana State University School of Medicine.

Professional affiliations included: diplomate of the American Board of Pathology, member of the College of American Pathologists, the American Society of Clinical Pathologists and American Society of Cytology.

Survivors include his widow, Mrs. Joan V. Mullins of Evans where they made their home; four sons, Donald Mullins, Jacksonville, Fla., Dr. Franklin Mullins, III, Robert Frederick Mullins and Joseph Mullins, Evans; three daughters, Deborah C. Mullins, Augusta, Julia Marie Mullins and Jennifer Mullins, Evans; parents, the Rev. and Mrs. D. Frank Mullins, Sr., Mansfield; four brothers, Albert Mullins and Dr. William B. Mullins of Augusta, Gene Mullins and Fred Mullins of Mansfield; sister, Mrs. Mary Bowden of Augusta.

Cecil A. White, Jr.

Cecil A. White, Jr., past president of the Richmond County Medical Society, died April 6.

The Waycross native had practiced in Augusta since 1955 and was a veteran of World War II, serving in the U.S. Army. He was a member of Richmond County Journal Club, AMA and Church of the Good Shepherd. He had been selected as a delegate to the MAG 119th Annual Session.

Dr. White is survived by his widow, Mrs. Darleen Hess White of North Augusta; son, Eric Scott White, Burlington, N.C.; four daughters, Mary Katherine White, Laurie Elizabeth White and Jane Ellen White

of Burlington, N.C., and Mrs. Deanne Marie Plunkett of North Augusta; sister, Mrs. F. D. Hereford, Falls Church, Va.; brother, Robert A. White, Sr., Atlanta.

Clarence Hill Willis, Jr.

C. H. "Jack" Willis, Jr., 65, died February 1 in Augusta. The son of a physician, Dr. Willis was born in Barnesville.

After receiving an M.D. degree from Medical School in Augusta in 1942, he received postgraduate training at University Hospital in that city and at Jackson Memorial Hospital in Miami. He began his career in gen-

eral practice, but later undertook additional training in anesthesiology and began working in that specialty. In recent years Dr. Willis had been associated with Stephens County Hospital in Toccoa and Gross Mercer Hospital in Vidalia.

His survivors include his widow, Mrs. Pauline Quatlebaum Willis of Augusta; daughters, Mrs. Amos Martin of Washington, Mrs. Woodrow S. Newman, Suzanne Willis and Marie Willis of Augusta; sons, Robert Willis, Griffin, M. David Willis of Augusta, and Clarence Hill Willis, III, of Miami, Fla.; sister, Mrs. Maurice Belding of Augusta.

THE MONTH IN WASHINGTON

The Administration has notified the American Medical Association it is "prepared to review thoroughly the regulations governing the medical profession" in the Phase 3 controls that continue the limits on physicians' fee increases.

The Administration's letter avoided a direct reply to the AMA's petition of January 15 to President Nixon urging that physicians be exempted from the Phase 3 controls as has been most of the rest of the economy.

John Dunlop, director of the Cost of Living Council, said the President had asked him to respond to the AMA letter. Dunlop said "having assumed responsibility for the economic stabilization program last month, I am now prepared to review thoroughly the regulations governing the medical profession."

"As you know," wrote Dunlop to John R. Kernodle, M.D., Chairman of the AMA Board of Trustees, "the health field has been persistently among the most inflationary areas in our economy, and I am sure it is our goal to alter that trend."

The AMA had told the President that physicians' fees rose only 1.7 per cent during the first 12 months of Phase 2. "... we have surpassed the original expectations," said Dr. Kernodle in the AMA letter to the President. "In view of our demonstrated success during the past year, you can imagine our dismay . . . that the medical profession has once again been singled out under special controls."

Dunlop's letter did not mention the AMA's request for a meeting with President Nixon and his top economic advisers to discuss the issue.

In his letter to Dr. Kernodle, Dunlop said: "We are presently in the process of appointing members to the new Health Industry Advisory Committee and I assure you that the views of physicians will be represented on that committee. As soon as an executive director for the committee is named, I will have him contact you for suggestions on how best to meet our goals for controlling health care costs under Phase 3."

"Meanwhile, I know the federal government can count on your cooperation in following the legal requirements now in effect, and I look forward to working with you to evaluate new alternatives."

Human Experimentation

The use of human subjects in medical research is essential for the benefit of society despite the fact that it

will place some participants at a calculated disadvantage, the American Medical Association told Congress.

The AMA comments were made to Senator Kennedy's Senate health subcommittee in hearings on the subject of human experimentation and if a need exists for federal legislation to forestall abuses.

William R. Barclay, M.D., Assistant Vice-President of the AMA, told the senators that. "The practice of medicine is both an art and a science, and we are constantly seeking new means to improve the quality and length of life. The evolution of sound medical practice through the years has reduced the incidence of pain and has done much to advance the cause of human dignity. These procedures, however, today as always, require the weighing of risk against benefit at every level of professional discretion. It is evident that there is a certain degree of risk attendant to any medical procedure.

"But if we are to continue to improve our high standards of patient care, we must maintain our initiatives in biomedical research. The accomplishments of modern medical practice testify to the merits of continued research. Such advances are hard won, but the benefits are beyond question.

"Medicine as a science must conduct experimentation if it is to progress rather than stagnate. Experimentation is an essential principle of all sciences, be they biological or physical. Scientific experiments are conducted both to test new hypotheses and to reexamine the validity of accepted hypotheses.

"A medical experiment with human subjects is sometimes referred to as a clinical trial. As such it should be a test of a reasonable hypothesis based on sound laboratory data. It should not be a random groping for information. A well designed clinical trial has elements in its design which assure that it will be a useful and a justifiable undertaking.

"... A human experiment, by its very nature, establishes a set of circumstances which will place some of the participants at a calculated disadvantage. Generally a trial is established to answer the question, 'Is treatment A better than treatment B?' No definitive answer to this question can be obtained until the test is conducted over an adequate period of time and sufficient data has been gathered by which to measure the relative response of the subject.

"... Through the process of clinical investigation,

which we have described here, drugs and procedures become available for widespread usage in patient care.

"... We note that it is the Committee's hope that these hearings will encourage continued support of and advancement of biomedical research. If we are to continue to increase our knowledge and continue to improve medical care for the benefit of society, medical research using human subjects is essential," Dr. Barclay concluded.

Diet Plan Condemned

The Council on Foods and Nutrition of the American Medical Association has labeled the dietary recommendations of the current best-seller book, *Dr. Atkins' Diet Revolution*, as unscientific and potentially dangerous to health.

The book recommends a sharply restricted intake of carbohydrates to lose weight. The author is Robert C. Atkins, M.D., of New York City.

"The 'diet revolution' is neither new nor revolutionary," the AMA Council declared in a formal statement analyzing the book's recommendations.

"It is a variant of the 'familiar' low carbohydrate diet that has been promulgated for years. The rationale advanced to justify the diet is, for the most part, without scientific merit."

Even more serious: "The Council is deeply concerned about any diet that advocates an 'unlimited' intake of saturated fats and cholesterol-rich foods (another aspect of the Atkins diet)."

Individuals responding to such a diet with a rise in blood fats will have an increased risk of coronary artery disease and atherosclerosis (hardening of the arteries), particularly if the diet is maintained over a prolonged period, the Council said.

The book states that the diet promotes production of a "fat mobilizing hormone" (FMH) . . . "and the production of FMH is the whole purpose of this diet—and the reason it works when all other diets fail." According to Dr. Atkins, "FMH releases energy into your bloodstream by causing the stored fat to convert to carbohydrate."

No such hormone as a "fat mobilizing hormone," has been established in man, said the AMA Council. In addition, no appreciable conversion of fat to carbohydrate occurs in the human body.

Carbohydrates are organic chemical substances containing carbon, hydrogen and oxygen. They are important sources of energy for the body. Sugar and starches, such as potatoes, rice and wheat flour, are important sources in the everyday diet.

"Any grossly unbalanced diet, particularly one which interdicts the 45 per cent of calories that is usually consumed as carbohydrates, is likely to induce some anorexia (loss of appetite) and weight reduction if the subject is willing to persevere in following such a bizarre regimen. However, it is unlikely that such a diet can provide a practicable basis for long-term weight reduction or maintenance, namely, a life-time change in eating and exercise habits," the Council declared.

The Council urged physicians to counsel their pa-

tients as to the potentially harmful effects of the Atkins diet.

"It is unfortunate that no reliable mechanism exists to help the public evaluate and put into proper perspective the great volume of nutritional information and misinformation with which it is constantly being bombarded," the Council statement said.

The Council declared that publishers and writers who advise the public on diet and nutrition "Have a unique responsibility to insure that such information and advice is based on scientific facts established by responsible research."

Emergency Services

It appears likely that Congress this year will pass legislation to improve emergency medical services throughout the nation. Both the Senate and the House have opened hearings on several bills that would provide federal funds to assist local governments in improving ambulance and emergency room services.

Among the major bills addressing itself to emergency medical care is one developed by the AMA. Sponsored by Senator J. Glenn Beall (R.—Md.) and by Representative James Hastings (R.—N.Y.), the AMA bills (S 654 and H. R. 4952) provide for the establishment of a comprehensive emergency medical system across the nation. Direction and financial assistance would be at the federal level, however the programs would be developed at the community level.

In outlining the AMA bill before a subcommittee of the House, Roy M. Baker, M.D., Jacksonville, Fla., summed up the extent of the problem by excerpting certain statistics from a recent report published by the National Research Council.

"Accidental injury and acute illness generate a staggering demand on ambulance and rescue services, allied health personnel, physicians, and hospitals for the delivery of emergency medical services. Accidental injury is the leading cause of death among all persons aged 1 to 38. Each year more than 52 million U.S. citizens are injured, of whom more than 110,000 die, 11 million require bed care for a day or more, and 400,000 suffer lasting disability at a cost of nearly \$3 billion in medical fees and hospital expenses and over \$7 billion in lost wages. Those requiring hospitalization occupy an average of 65,000 beds for 22 million bed-days under the care of 88,000 hospital personnel. This hospital load is equivalent to 130 500-bed hospitals. Of the more than 700,000 deaths from heart disease each year, the majority are due to acute myocardial infarction and more than half of these deaths occur before reaching a hospital. Approximately 40 million persons seek care each year in hospital emergency departments as a result of accidents, heart disease, stroke, poisoning, diabetic coma, convulsive disorders, and many other illnesses."

In his testimony, Dr. Baker noted as a matter of interest for the Committee, there are currently seven two-year emergency residency programs in operation. Beginning on July 1, 1973, there will be an additional seven residency programs operational. In addition,

there are three institutions conducting short-course training programs in the field of emergency medicine.

Drug Abuse Report

While the abuses of alcohol, heroin and other drugs show no signs of disappearing soon and may even increase, drugs do not threaten to destroy society, the National Commission on Marijuana and Drug Abuse has told Congress and President Nixon.

Making more than 100 recommendations to de-emphasize government involvement in the drug field, which the panel sharply criticized, and re-emphasized family, church and community involvement, the 481-page report concluded:

- "The Commission sees little evidence of any decline in the rate of experimental use, particularly of marijuana and hallucinogenic drugs, by young people. . . . Youthful experimentation will remain one of the most difficult aspects of the drug problem."

- "The Commission does not anticipate a quick end to the heroin problem. A large segment of the current heroin-dependent population resists any form of treatment while new users continue to be recruited."

- "The Commission does not anticipate the imminent discovery of a cure or vaccine for drug dependence. Compulsive drug use does not seem to be the kind of phenomenon for which science will discover a 'magic bullet.'"

- "The Commission foresees a possible continuing increase in the already extensive phenomenon of circumstantial use, slowed only by reduced availability of specific substances within legitimate medical channels. Only an effective long-term policy can forestall or diminish this development."

- "The drug problem, as perplexing and extensive as it is, is not going to bring about the collapse of our

society. We will make some progress in dealing with it, but we should not harbor unrealistic hopes for the future."

The report by the high-level Commission, which a year ago recommended that all criminal penalties for personal use and possession of marijuana be abolished, came as the White House announced plans to group all federal drug law enforcement under one agency in the Justice Department.

Catastrophic Health Insurance

Senator Thomas McIntyre (D.—N.H.) and Representative Omar Burleson (D.—Texas) introduced the National Health Care Act of 1973, the plan developed by the private health insurance companies.

The 1973 proposal provides catastrophic health insurance for every individual up to \$250,000. Any person who incurs \$5,000 or more in medical expenses during a 12-month period would be eligible for up to \$250,000 in benefits, even if some or all of his expense is reimbursed by insurance. McIntyre and Burleson said this new provision answers a major health fear of millions of Americans—fear of catastrophic illness or injury.

Cost to the government in new revenues would be \$8.1 billion. The bill provides tax disincentives for employers whose group plans don't meet standards and tax incentives for individuals not belonging to groups to encourage purchase of insurance. State pool plans are provided for the poor and near poor.

The health insurance industry bill now brings the count of major national health insurance proposals to three . . . AMA's Mediscredit plan and the sweeping proposal of organized labor were introduced earlier. Still to be seen is this year's proposal of the Nixon Administration.

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MAG General Session (First Session)

119th Annual Session of the Medical Association of Georgia
Friday, May 11, 1973

THE FIRST GENERAL SESSION of the 119th Annual Session of the Medical Association of Georgia was called to order by First Vice President Braswell E. Collins, M.D., Macon, at 9:00 a.m. in the Embassy Room, Richmond Hotel, Augusta, Ga. on May 11, 1973.

Dr. Collins welcomed those present and briefly acknowledged the outstanding hospitality being extended by the City of Augusta and the Richmond County Medical Society. Dr. Collins then called on the Reverend Samuel W. Edleman, Jr., Rector of the St. Paul Episcopal Church of Augusta for the invocation.

Dr. Collins asked the assembly to stand for the presentation of the colors by the Fort Gordon Color Guard and to remain standing for the singing of the National Anthem by Mrs. John G. Bates, president-elect of the MAG Woman's Auxiliary, who was accompanied by Mrs. Theo G. Thedaos. Dr. Collins then recognized Dr. Luther M. Thomas, president of the Richmond County Medical Society, who extended words of welcome to the MAG from the host society. An additional greeting was extended to the assembly by the Honorable Louis Newman, mayor of the City of Augusta.

Dr. Collins then acknowledged the presence of the president of the Georgia Pharmaceutical Association, Mr. Alton B. Greenway; Mr. Roger Lane, executive director, Georgia Pharmaceutical Association, and the president of the Georgia State Nurses Association, Mrs. Katherine Suggs.

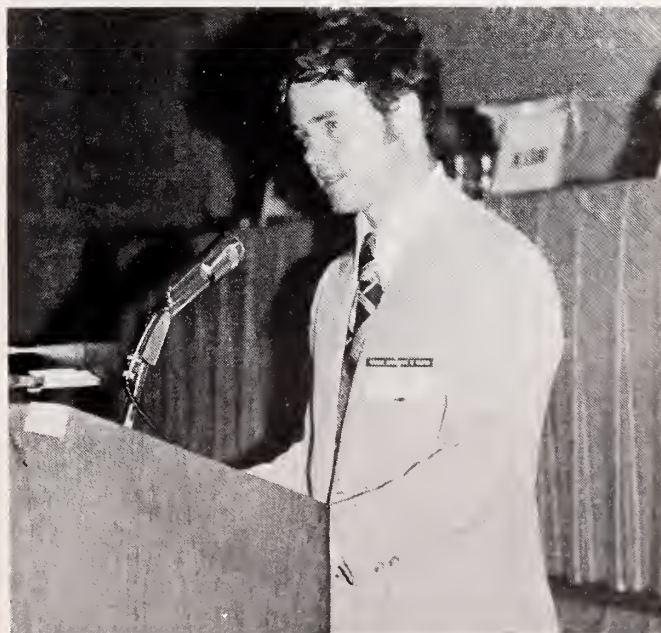
Dr. Collins then introduced Mr. James Conner, Director of the Augusta College Choir who led the choir in a choral presentation.

Dr. Collins next called on Dr. F. G. Eldridge to escort Mrs. Cliff Moore, Jr. of Rome, president of the Woman's Auxiliary to the Medical Association of Georgia to the podium for the purpose of delivering

the report of the Auxiliary to the General Session. Mrs. Moore's report highlighted the many activities of the Auxiliary during the past year. Mrs. Moore concluded her remarks by introducing Mrs. Erle E. Wilkinson of Nashville, Tenn., president of the Woman's Auxiliary to the Southern Medical Association. Mrs. Wilkinson extended greetings to the Assembly.

Dr. Collins then acknowledged the keen interest with which MAG had followed the activities of the two student AMA Chapters in Georgia. He called on Mr. Charles Greene, president of the SAMA Chapter at the Medical College of Georgia and extended him the privileges of the floor. Mr. Greene addressed the Assembly.

Dr. Collins next called on Dr. C. E. Bohler of Brooklet, Ga., president-elect, to deliver the address of the incoming president of the Association.



Charles Greene, president of the SAMA Chapter of the Medical College of Georgia

Dr. Bohler responded with an address that acknowledged PSRO as the principal problem area to be dealt with during the coming year by the Association.

Dr. Collins thanked Dr. Bohler for his thought-provoking message and proceeded with several announcements including the importance of visiting all of the commercial exhibits, the Saturday night an-

nual banquet, the Sunday morning prayer breakfast, and the fifth running of the Medical Mile.

At this point, Dr. Collins announced that the First MAG General Session would be recessed and the meeting turned over to Harrison Rogers, M.D., of Atlanta, speaker of the MAG House of Delegates, to preside at the First Session of the House of Delegates Meeting.

First Session House of Delegates

Friday, May 11, 1973

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., M.D., Atlanta at 10:00 a.m. in the Embassy Room, Richmond Hotel, Augusta, Ga. The House of Delegates met in conjunction with the 119th Annual Session of MAG. The Speaker extended greetings to all delegates in attendance and briefly reviewed the schedule for the transaction of business by the House of Delegates during its two sessions on Friday, May 11, and Sunday, May 13, 1973.

Speaker Rogers called for a report of the delegates in attendance. Timothy Harden, Jr., M.D., of Decatur, chairman of the Credentials Committee of the House reported that there were 106 duly elected delegates present representing 37 medical societies, and accordingly announced that a quorum was present. (A final tally by the Credentials Committee indicated 119 Delegates in attendance at the First Session.)

Attendance

BARTOW: Richard A. Griffin, III; BEN HILL-IRWIN: George E. Mixon; BIBB: F. V. Kay, G. C. Schlottman, S. Charlotte Neuberg, John G. Etheridge, C. G. Magnan; CARROLL-DOUGLAS-HARALSON: J. Larry Boss and Clark Robinson; OGEECHEE RIVER: Charles R. Richardson; GEORGIA MEDICAL SOCIETY: J. Robert Logan, Carson B. Burgstiner, F. Debele Maner, Dearing A. Nash and T. A. Hetherington; ELBERT: John B. O'Neal, III; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald L. Brannon and F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, Charles Rey, Donald R. Rooney, W. C. Mitchell, James H. Manning, Gary Palmer, F. Norman Bowles and Robert Coggins; COFFEE: Richard L. Benson; COLQUITT: John Pierce Tucker; COWETA: Lewis R. Collins; DEKALB: L. S. McGinnis, John Heard, George S. Statham, L. L. Freeman, Fred Amatrian, Charles McDowell, Duane Blair

and L. C. Buchanan; DOUGHERTY: Robert D. Waller, J. Dan Bateman, Charles D. Hollis and D. M. Boyette; EMANUEL: Robert J. Moye; FLINT: Joe T. Christmas; FLOYD-POLK-CHATTOOGA: William D. Dooley, James H. Smith, Jack R. Meacham; MEDICAL ASSOCIATION OF ATLANTA: Harrison L. Rogers, Jr., James A. Kaufmann, Charles E. Todd, John K. Schellack, William D. Logan, J. R. B. Hutchinson, A. A. Rayle, Jr., Alton V. Hallum, Jr., Harold Ramos, J. Harold Harrison, Joseph L. Girardeau, Thomas L. Tidmore, Jr., Louis Felder, J. Rhodes Haverty, C. R. Moorhead, W. Scott James, Robert L. Brown, Edwin C. Evans, L. Newton Turk, III, Robert E. Wells, A. J. Brumbley, J. Frank Walker, D. G. Whitney, John McCoy, W. Dan Jordan, Thomas E. Whitesides, John R. McCain and John S. Atwater; GLYNN: Edwin A. Mayo, M. A. Glucksman and William J. Smith; GORDON: R. D. Walter; HALL: Billy S. Hardman, Harvey Newman and Larry N. Durisch; PEACH BELT: Virgil W. McEver and W. E. Weems; JEFFERSON: C. Roy Williams; LAURENS: Robert Oliver; McDUFFIE: Thomas E. Averitt; MUSCOGEE: E. M. Molnar, L. J. Smith, B. R. Maughon, A. J. Kravtin, J. H. Deaton, Jack A. Raines; OCONEE VALLEY: H. A. Thornton; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Stuart H. Prather, Jr., Julius T. Johnson, Carl Jelenko, Ronald F. Galloway, Preston D. Ellington, Luther M. Thomas, Jr., Wm. E. Barfield and Claud A. Boyd; SOUTH GEORGIA: William L. Dickson, Joe C. Stubb; SPALDING: James Skinner; STEPHENS: C. Peter Lampros; SUMTER: John H. Robinson; THOMAS-BROOKS-GRADY: Donald J. McKenzie and Frank R. Miller; TIFT: Terrell L. Davis; TROUP: H. Hilt Hammett and Joseph M. Almand; WALKER-CATOOSA-DADE: Ted D. Cash and Murphy K. Cureton; UPSON: T. A. Sappington; WARE: F. E. Davis and S. William Clark; WAYNE: Ollie O. McGahee, Jr.; WHITFIELD: James J. Oosterhoudt and Earl T. McGhee; WORTH: H. G. Davis.

Dr. Rogers thanked the chairman of the Committee on Credentials and announced that the business of the House could now proceed. He requested that only delegates sit in the area reserved for MAG dele-

gates since the privilege of the floor was limited to members and ex officio members of the House of Delegates and that voting must be limited to duly elected delegates identified by their special delegate ribbon badges.

Dr. Rogers introduced J. Rhodes Haverty, M.D. of Atlanta, vice speaker of the House of Delegates and fully explained the methods of consideration of business to be brought before the House of Delegates.

Speaker Rogers announced the appointment of the House of Delegates Credentials Committee and the appointment of the Tellers Committee of the House as follows:

CREDENTIALS COMMITTEE: Timothy Harden, Jr., Decatur, chairman; Donald L. Branyon, Athens; William F. Coleman, Hawkinsville.

TELLERS COMMITTEE: Billy S. Hardman, Gainesville, chairman; Grady Clinkscales, Atlanta; Russell A. Acree, Hahira.

The Speaker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: Charles R. Richardson, Statesboro, chairman; James H. Smith, Rome, vice chairman; Linton H. Bishop, Atlanta; Harold S. Ramos, Atlanta; Thomas A. Averitt, Thomson; James M. Skinner, Griffin; T. A. Hetherington, Savannah.

REFERENCE COMMITTEE B: Charles B. Hollis, Albany, chairman; John P. Tucker, Moultrie, vice chairman; Edwin C. Evans, Atlanta; Louis R. Collins, Newnan; F. E. Davies, Waycross; Roy Vandiver, Decatur.

REFERENCE COMMITTEE C: W. Dan Jordan, Atlanta, chairman; C. Roy Williams, Wadley, vice chairman; F. Norman Bowles, Austell; William M. Headley, Milledgeville; Warren Baxley, Blakely; and Dewey Barton, Valdosta.

REFERENCE COMMITTEE D: Beverly Sanders, Macon, chairman; Luther M. Thomas, Augusta, vice chairman; Richard J. Turner, Clayton; Dearing A. Nash, Savannah; Louis Felder, Atlanta; and Lynn Huie, Monroe.

REFERENCE COMMITTEE F: James H. Manning, Marietta, chairman; John S. Atwater, Atlanta, vice chairman; Duane Blair, Decatur; Robert D. Waller, Albany; James H. Sullivan, Columbus; and Stuart H. Prather, Augusta.

To expedite the adoption of the minutes of the 1972 Sessions of the House of Delegates held in conjunction with the 118th Annual Session of the Medical Association of Georgia, convened on May 12-14, 1972 at the Macon Hilton Hotel, Macon, Ga., the Chair entertained a motion that the minutes as published in the June 1972 issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be approved as published.

Nominations

Speaker Rogers called on the House to proceed with the nominations of officers, AMA delegates and

alternates, and requested that nominating speeches be limited to two minutes and seconding speeches be limited to one minute each.

Speaker Rogers recognized J. Rhodes Haverty, M.D., vice speaker, for the purpose of announcing his resignation as vice speaker effective May 13, 1973. The Speaker acknowledged the resignation and indicated that nominations to this office would be called for at the appropriate time in the order of business.

The Speaker asked for nominations for the office of MAG president-elect and the following nominations were made:

PRESIDENT-ELECT: John Rhodes Haverty, Atlanta, nominated by J. Frank Walker, Atlanta, Medical Association of Atlanta; Dr. Haverty's candidacy was seconded by David A. Wells, Dalton; Edwin C. Evans, Atlanta; Carson B. Burgstiner, Savannah; S. Lamar McGinnis, Jr., Decatur.

Beverly W. Forester, Macon, nominated by Earl T. McGhee, Dalton, Whitfield County Medical Society; Dr. Forester's candidacy was seconded by Braswell Collins, Macon; T. A. Sappington, Thomaston; Beverly Sanders, Macon; Charlotte Neuberg, Macon; James Smith, Rome; R. W. Walter, Calhoun who relinquished the floor to permit a seconding speech by John M. Martin of Augusta, a non-delegate; and G. C. Schlottman, Macon.

There being no further nominations for the office of president-elect, on motion duly made and seconded, the nominations were closed.

SECOND VICE PRESIDENT: Luther M. Thomas, Augusta, was nominated for the office of MAG's second vice president by Ronald F. Gallo-way, Richmond County Medical Society; seconded by Ollie O. McGahee, Jesup; J. Daniel Bateman, Albany; and Stuart H. Prather, Jr., Augusta.

There being no further nominations for the office of MAG second vice president, on motion duly made and seconded, the nominations were closed.

COUNCILORS AND VICE COUNCILORS: Speaker Rogers then quoted from Chapter V, Section 2 of the Bylaws which authorize the election of councilors and vice councilors from district societies and component county medical societies, observing that the following district medical societies and county medical societies had complied with the terms of the Bylaws and had accordingly elected the following councilors and vice councilors:

First District Councilor: Albert M. Deal, M.D., Statesboro (1976)

First District Vice Councilor: Leon E. Curry, M.D., Metter (1976)

Second District Councilor: J. Daniel Bateman, M.D., Albany (1976)

Second District Vice Councilor: Frank R. Miller, M.D., Thomasville (1976)

Third District Councilor: John H. Robinson, Americus (1976)

Third District Vice Councilor: B. Lamar Pilcher, M.D., Warner Robins (1976)

Medical Association of Atlanta Councilor: J. Harold Harrison, M.D., Atlanta (1976)

Medical Association of Atlanta Vice Councilor: William W. Moore, Jr., M.D., Atlanta (1976)

Georgia Medical Society Councilor: L. R. Lanier, Jr., M.D., Savannah (1976)

Georgia Medical Society Vice Councilor: Irving Victor, M.D., Savannah (1976)

AMA Delegates

Speaker Rogers then called for nominations for MAG delegates to the American Medical Association. He reminded the Assembly that all incumbents would serve until December 31, 1973 at which time the new terms of office would begin for the candidates elected at this meeting.

AMA DELEGATE: For the office held by J. W. Chambers of LaGrange, the term beginning January 1, 1974 and expiring December 31, 1975. J. W. Chambers, LaGrange, was nominated by H. Hilt Hammett, LaGrange, and seconded by James Skinner, Griffin, and Braswell Collins, Macon. There being no further nominations for this office, on motion duly made and seconded, it was voted to close nominations.

For the office held by John S. Atwater of Atlanta, the term beginning January 1, 1974 and expiring December 31, 1975. John S. Atwater, Atlanta, was nominated by Edwin C. Evans, Atlanta, and seconded by T. A. Sappington, Thomaston, Ollie O. McGahee, Jesup, Carson B. Burgsteiner, Savannah. There being no further nominations for this office, on motion duly made and seconded, it was voted that nominations be closed.

AMA ALTERNATE DELEGATE: For the office held by F. G. Eldridge of Valdosta, the term beginning January 1, 1974 and expiring December 31, 1975. F. G. Eldridge of Valdosta was nominated by L. C. Buchanan, Decatur, and seconded by Joseph T. Christmas, Vienna. There being no further nomination for this office, on motion duly made and seconded, it was voted that nominations be closed.

For the unexpired term of office held by Henry S. Jennings, Gainesville, the term beginning May 13, 1973 and expiring December 31, 1973. Luther M. Vinton, Jr., Avondale Estates, was nominated by Earnest C. Atkins, DeKalb County, and seconded by Carson B. Burgsteiner, Savannah, Earl T. McGee, Dalton, and J. Daniel Bateman, Albany.

Speaker Rogers then announced that it would be necessary for the House to elect an alternate delegate for a full two-year term beginning January 1, 1974 and expiring December 31, 1975 to fill the seat previously held by Henry S. Jennings, M.D. of

Gainesville. By acclamation of the House, Luther M. Vinton, Jr., Avondale Estates, was elected to this full two-year term.

Vice Speaker, House of Delegates

To fill the unexpired term of J. Rhodes Haverty, vice speaker of the House of Delegates, Speaker Rogers called for nominations for this post.

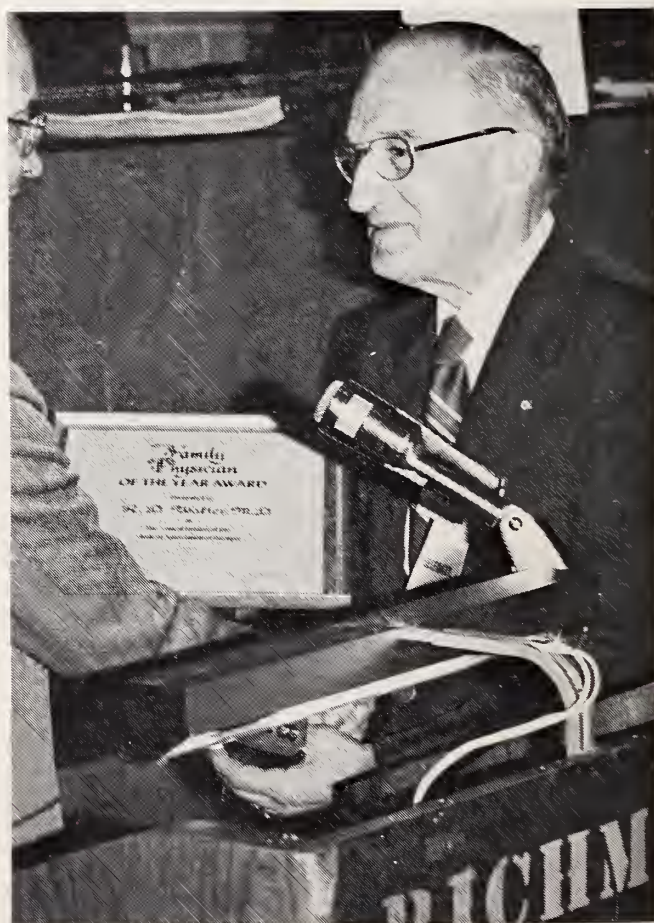
L. C. Buchanan, Decatur, was nominated by C. E. Bohler, Brooklet, and seconded by David A. Wells, Dalton, Ronald F. Galloway, Augusta, H. Hilt Hammett, LaGrange, Jack Raines, Columbus and John Kirk Train, Savannah.

There being no further nominations for this office, on motion duly made and seconded, it was voted to close the nomination.

Family Physician of the Year Award

The Speaker recalled that the selection as Family Physician of the Year is made by the Georgia Academy of Family Physicians, and accordingly called on Dr. Ollie O. McGahee, president of Georgia Academy of Family Physicians to make the presentation of this award.

Dr. McGahee announced that the Board of Directors of the Georgia Academy had selected as the



Calhoun's Robert D. Walter happily accepts his award as Family Physician of the Year from Ollie O. McGahee, president of the Georgia Academy of Family Physicians.



"The AMA, for its part, intends to monitor PSRO closely—not only to help ensure its effectiveness . . . but to help safeguard the interests of physicians." . . . John R. Kernodle, M.D., Chairman, AMA Board of Trustees.

1973 recipient, Dr. Robert D. Walter of Calhoun, Ga.

Special Address

As the next order of business, Speaker Rogers recognized Dr. John R. Kernodle, chairman of the AMA Board of Trustees, for a special address to the House. Dr. Kernodle centered his remarks on PSRO and other federal programs having a direct effect on the practice of medicine.

Annual Reports

Speaker Rogers called for the annual reports of officers, council, councilors, vice councilors, AMA delegates, association committees, and other reports to be introduced at this Session which are listed below with the appropriate reference committee indicated to which those reports were referred. He observed that the full report, the action of the reference committee, and the subsequent action of the House of Delegates on each report would be listed under the proceedings of the Second Session of the House of Delegates on those reports and resolutions which were referred to Reference Committees. (See pages 189-230.)

OFFICERS

President—Reference Committee D
President-Elect—Reference Committee B
First Vice President—Not Referred
Second Vice President—Reference Committee D
Secretary—Reference Committee D
Treasurer—Not Referred
Speaker of the House—Reference Committee D

COUNCILORS AND VICE COUNCILORS

Chairman of Council—Reference Committee B
First District Councilor—Not Referred
Second District Councilor—Not Referred

Third District Councilor—Not Referred
Sixth District Councilor—Not Referred
Seventh District Councilor—Not Referred
Eighth District Councilor—Not Referred
Ninth District Councilor—Not Referred
Tenth District Councilor—Not Referred
Bibb County Medical Society Councilor—Not Referred
Cobb County Medical Society Councilors—Reference Committee A
DeKalb County Medical Society Councilor—Not Referred
Georgia Medical Society Councilor—Not Referred
Medical Association of Atlanta Councilors—Not Referred
Muscogee County Medical Society Councilor—Not Referred
Richmond County Medical Society Councilor—Reference Committee D

ASSOCIATION COMMITTEES

Annual Session—Reference Committee A
Constitution and Bylaws—Reference Committee C
Finance (1973-74 Budget)—Reference Committee F
Professional Conduct and Medical Ethics—Not Referred
Emergency Medical Services—Reference Committee A
Cancer—Not Referred
Communications—Reference Committee D
Education—Reference Committee C
Historical—Not Referred
Insurance and Economics—Reference Committee C
Legislation
National—No Recommendations
State—No Recommendations
Maternal and Infant Welfare—Reference Committee A
Medicine and Religion—Not Referred
Mental Health—Reference Committee A
Occupational Health—Not Referred
Peer Review—Reference Committee B
Physician-Lawyer Liaison—Reference Committee A
Private Practice—Not Referred
Quackery—Reference Committee C
Rural Health—Reference Committee A
School Child Health—Not Referred
Liaison with Georgia State Medical Association—Reference Committee D
Ad Hoc Committee to Study Medical Disciplinary Laws—Not Referred

SPECIAL REPORTS

Report of the *Journal*—Reference Committee D
Woman's Auxiliary to the Medical Association of Georgia—Reference Committee F
Georgia Regional Medical Program (Coordinator and Director)—Reference Committee F

- Georgia Medical Care Foundation—Reference Committee B
- Experimental Medical Care Review Organization—Reference Committee B
- Interspecialty Council—Reference Committee D

Speaker Rogers called attention to the reports which were shown as containing no recommendations and thus had not been referred to any reference committee. He reminded the delegates of their right to request any report be referred and accordingly a request from a delegate to refer the report on Insurance and Economics was requested, and this report was referred to Reference Committee C. At this point the Speaker recognized Dr. Earnest C. Atkins, secretary, who moved that the First Session of the House of Delegates accept with commendation and file for information all reports that had not been specifically referred to a Reference Committee. This motion was duly seconded and adopted by the House. The Speaker then announced that all reports not referred to committee would be filed for information. They are as follows:

FIRST VICE PRESIDENT

BRASWELL E. COLLINS, M.D.

Your first vice president wishes the entire membership to learn more about the increasing duties of your headquarters staff at MAG. When in Atlanta, a member should visit the staff and see the action. Help from the membership through committee work, personal suggestion and dues are appropriate.

It is gratifying to see an increase in membership activity throughout the state. The MAGNET session for all members this winter in Atlanta was superior.

We should all at least attend the annual MAG session held in the spring and MAGNET orientation meeting held in the winter.

TREASURER

CARSON B. BURGSTINER, M.D.

It is an honor and privilege to serve the Medical Association of Georgia as your treasurer for the year 1972-73. This first year in office has truly been a learning experience. Being a member of Council, the Executive Committee of Council, attending AMA meetings, as well as committee memberships has kept the Treasurer busy and on the move.

This year has seen liquid funds accrued by our recent treasurer, Dr. John S. Atwater, more than doubled by prudent reinvestment through our director of finance, Mr. L. B. Storey, Jr., bolstered by the expertise of Dr. "Tex" Eldridge, our chairman of Finance.

Dues continue to come in from the membership this year at a good pace, solidifying the financial position of your Medical Association. Finances have reached an all-time high with liquid funds earning interest rates in excess of 6 per cent until they are needed for budgeted items. Undoubtedly our net worth will increase again when the audit for the year ending May 31, 1973 is presented.

Regarding our government programs, the future is

not bright, as there is reasonable doubt that the Georgia Regional Medical Program will be continued, and the Cancer Survey Program will cease to operate on August 31, 1973. The elimination of these programs will cause our indirect cost reimbursement to drop approximately \$72,000 annually.

I would like to thank our secretary, Dr. Earnest C. Atkins, for his untiring effort in working with our MAG staff, always bringing them his optimistic attitude, good ideas, and always restoring their confidence.

Lastly, I would like to say that Mr. L. B. Storey, Jr. has demonstrated a rare dedication to MAG through his knowledge of accounting and financial affairs, as well as perseverance in educating your new treasurer. I have enjoyed the past year, and remain "bullish" on the financial future of MAG.

FIRST DISTRICT COUNCILOR

C. E. BOHLER, M.D.

As councilor for the First District, I have attended all Council meetings during the year.

I have attempted to keep all First District Component Medical Societies aware of Medical Association of Georgia and American Medical Association actions during the year.

The annual First District meeting will be held in Statesboro prior to the annual session of Medical Association of Georgia.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Ogeechee River				
William F. Kent				
Statesboro	21	19	22	20
Burke				
Charles G. Green				
Waynesboro	7	4	7	5
Emanuel				
D. L. Kennedy				
Adrian	6	5	6	5
Laurens				
Grady E. Longino				
Dublin	40	23	41	26
Screven				
Katrine R. Hawkins				
Sylvania	5	5	5	5
Southeast Georgia				
Travis R. Nobles				
Vidalia	17	11	14	9
	96	67	95	70

SECOND DISTRICT COUNCILOR

J. DANIEL BATEMAN, M.D.

SECOND DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Colquitt				
R. M. Joiner				
Moultrie	17	15	15	13

Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	16	8	14	7
Dougherty				
T. Gray Fountain				
Albany	72	59	79	59
Mitchell				
A. A. McNeill, Jr.				
Camilla	5	5	3	3
Southwest Georgia				
David Wetherby				
Fort Gaines	12	9	12	8
Thomas-Brooks-Grady				
Thomas F. Lear				
Thomasville	57	48	52	45
Tift				
Terrell Davis				
Tifton	19	14	22	15
Worth				
Robert T. Morgan				
Sylvester	5	5	5	3
	<u>203</u>	<u>163</u>	<u>202</u>	<u>153</u>

THIRD DISTRICT COUNCILOR

J. T. CHRISTMAS, M.D.

The Third District held two district meetings during the year, one in April and the other in October. Both meetings were very well attended and a good scientific program was presented. Officers for the 1973 year were elected at the October meeting.

The Councilor has attended both district meetings and all regular meetings of Council. In addition, the Councilor served on the Board of Directors of the Medical Care Foundation until June when illness forced his resignation from this Board.

In November, this Councilor attended one meeting of the Board of Human Resources at the request of the Executive Committee to represent Council. It was this Councilor's feeling that this meeting was a total waste of time and nothing was accomplished for the good of Council nor the Board of Human Resources by the Councilor's presence.

The Third District membership by societies shows a loss of two members and a loss of six AMA dues paying members.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	Members December 31, 1971 AMA Dues Paying Only	MAG	Members December 31, 1972 AMA Dues Paying Only
Flint				
Robert Garrett				
Vienna	15	14	13	12
Peach Belt				
Johann Manning				
Warner Robins	40	37	42	35
Randolph-Stewart-Terrell				
Earl A. Mayo				
Richland	11	11	10	10
Sumter				
William R. Anderson				
Americus	30	21	29	20
	<u>96</u>	<u>83</u>	<u>94</u>	<u>77</u>

SIXTH DISTRICT COUNCILOR

W. E. BARRON, M.D.

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	Members December 31, 1971 AMA Dues Paying Only	MAG	Members December 31, 1972 AMA Dues Paying Only
Clayton-Fayette				
F. A. Sams, Jr.				
Fayetteville	12	11	10	9
Coweta				
Lewis R. Collins				
Newnan	21	17	22	13
Meriwether-Harris				
William G. Chambless				
Hamilton	15	13	16	13
Spalding				
William V. Smith				
Griffin	47	38	47	41
Troup				
Cecil Major				
LaGrange	36	28	40	30
Upson				
J. T. Deen				
Thomaston	19	15	18	16
	<u>150</u>	<u>122</u>	<u>153</u>	<u>122</u>

SEVENTH DISTRICT COUNCILOR

DAVID A. WELLS

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	Members December 31, 1971 AMA Dues Paying Only	MAG	Members December 31, 1972 AMA Dues Paying Only
Bartow				
Virginia Hamilton				
Cartersville	11	6	11	6
Carroll-Douglas-Haralson				
Mary J. Touchton				
Carrollton	40	37	39	36
Floyd				
John R. Lovvorn				
Rome	93	70	94	68
Gordon				
Frank M. Alvarez				
Calhoun	9	8	10	9
Walker-Catoosa-Dade				
M. K. Cureton				
LaFayette	37	21	36	19
Whitfield				
Paul L. Bradley				
Dalton	51	41	54	45
	<u>242</u>	<u>184</u>	<u>244</u>	<u>183</u>

EIGHTH DISTRICT COUNCILOR

ROBERT E. PERRY, JR., M.D.

EIGHTH DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	Members December 31, 1971 AMA Dues Paying Only	MAG	Members December 31, 1972 AMA Dues Paying Only
Altamaha				
C. B. Kanavage				
Baxley	6	6	5	5

Ben Hill-Irwin				
C. Morgan Smith				
Fitzgerald	8	8	8	8
Coffee				
John Herndon				
Douglas	9	6	9	7
Camden-Charlton				
R. R. McCollum				
Kingsland	9	5	8	4
Glynn				
M. A. Glucksman				
Brunswick	53	46	55	47
Ocmulgee				
William J. Briggs				
Milan	17	14	15	13
South Georgia				
Paul Boone				
Valdosta	66	51	65	51
Telfair				
D. B. McRae				
McRae	5	4	5	4
Ware				
L. C. Durrence				
Blackshear	46	41	48	43
Wayne				
William A. Hitt				
Jesup	14	8	15	9
	233	189	233	191

NINTH DISTRICT COUNCILOR

PAUL T. SCOGGINS, M.D.

NINTH DISTRICT MEMBERSHIP

	Members December 31, 1971 AMA Dues Paying Only		Members December 31, 1972 AMA Dues Paying Only	
Counties and Secretaries	MAG		MAG	
Barrow				
W. Jack Dickens				
Winder	8	6	8	7
Blue Ridge				
H. E. Mitzelfelt				
Blue Ridge	5	4	5	4
Chattahoochee				
Rupert H. Bramblett				
Cumming	24	19	24	19
Cherokee-Pickens				
Carlton B. Hudson				
Canton	14	14	14	14
Elbert-Franklin-Hart				
Jack Hands				
Elberton	17	8	15	10
Habersham				
A. Dan Windham				
Demorest	10	6	10	6
Hall				
J. R. Wright				
Gainesville	67	62	70	60
Jackson-Banks				
S. A. Vickery				
Commerce	10	7	9	7
Rabun				
John T. Crenshaw				
Clayton	5	5	5	5
Stephens				
James C. Pickens				

Toccoa	22	19	21	17
	182	150	181	149

TENTH DISTRICT COUNCILOR

EDWIN W. ALLEN, JR., M.D.

TENTH DISTRICT MEMBERSHIP

	Members December 31, 1971 AMA Dues Paying Only		Members December 31, 1972 AMA Dues Paying Only	
Counties and Secretaries	MAG		MAG	
Baldwin				
David Cardoso				
Milledgeville	51	31	56	33
Crawford W. Long				
James Maxwell				
Athens	78	59	77	58
Jefferson				
James W. Pilcher				
Louisville	5	4	5	4
McDuffie				
E. J. Maxwell				
Thomson	7	5	5	5
Newton-Rockdale				
Karl S. VonSenden, Jr.				
Covington	12	5	12	4
Oconee Valley				
W. H. Rhodes, Jr.				
Union Point	12	10	12	10
Walton				
R. M. Tankesley				
Monroe	9	8	7	5
Washington				
J. W. Traer				
Sandersville	10	2	10	3
Wilkes				
M. C. Adair				
Washington	6	5	6	5
	190	129	190	127

BIBB COUNTY MEDICAL SOCIETY COUNCILOR AND VICE COUNCILOR

BRASWELL E. COLLINS, M.D.

MILTON I. JOHNSON, M.D.

This Society had a busy and successful year under the leadership of L. E. Dickey, M.D., president.

Outstanding programs included:

- Improving the physicians' image.
- Campaign to influence and welcome new physicians to Central Georgia.
- Approval and action to establish a greatly needed medical college in Macon.
- Organization of a local peer review committee to work with, but be independent of, MAG Foundation.
- Plans and action toward securing a full time executive secretary. This action results from an obvious need and the recommendations of the AMA Survey Team.

• Harrison Rogers, M.D. and MAG staff members, Jim Moffett and Adam Jablonowski, stimulated society members to greater activity in politics.

A later program by Mr. Charles Jones, president of the Macon Chamber of Commerce, was of the same nature and importance.

In August, a picnic for Central Georgia legislators was highly successful. Most politicians have felt that physicians are indifferent.

SIXTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bibb G. Wayne Bohanan Macon	183	155	180	153

DEKALB COUNTY MEDICAL
SOCIETY COUNCILOR

L. C. BUCHANAN, M.D.

FOURTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
DeKalb L. L. Freeman Chamblee	228	205	242	210

GEORGIA MEDICAL SOCIETY COUNCILOR

L. R. LANIER, JR., M.D.

FIRST DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Georgia Medical Society Harry H. McGee, Jr. Savannah	199	185	210	194

MEDICAL ASSOCIATION OF
ATLANTA COUNCILOR

JOHN T. GODWIN, M.D.

Most all meetings have been attended with active participation in many of the areas of interest of the Council. Much effort has been expended in attempting to modify and participate in Governor's reorganization activities.

FIFTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Medical Association of Atlanta Joseph L. Girardeau Atlanta	1209	959	1194	924

MUSCOGEE COUNTY MEDICAL
SOCIETY COUNCILOR

JACK A. RAINES, M.D.

THIRD DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Muscogee H. Daniel Sigman Columbus	147	116	173	124

COMMITTEE ON PROFESSIONAL
CONDUCT AND MEDICAL ETHICS

T. A. SAPPINGTON, M.D.

This committee has not had to have any special called meetings. It did meet at the Committee Conclave. We have had no real major problems to come before us that have not been resolved.

The chairman of this committee met with the other members of the Ad Hoc Committee concerning a Medical Disciplinary Board. It is felt that definite progress is being made toward the formation of such a board and it is hoped that this committee will soon meet again and some definite recommendations can be made as to the formation of such a board, that it will be formed, and be an active board.

The three months reports are being sent to the committee members and it is felt that this helps the committee in knowing what complaints are being received and what action is being taken.

COMMITTEE ON CANCER

HOKE WAMMOCK, M.D.

The Committee on Cancer with its various subcommittees has held numerous meetings and even telephone conferences. This included a full meeting of the Committee Conclave on August 12, 1972. Some six meetings in all have been held. Another one is scheduled for February 26, 1973, at which time we will review the National Cancer Act and the possibilities of funds to be available from this program, plus the possibility of having funds increased for the State-Aid Cancer Control Program in Georgia for 1974. The latter is doubtful.

The Committee on Cancer continues to function as a coordinating committee of the Cancer Control Program in Georgia with joint participation of all agencies concerned with cancer control: the Georgia Regional Medical Program, the Georgia Division of the American Cancer Society, and the Cancer Control Section of the Physical Health Division of the Board of Human Resources.

It is to be understood that the Medical Assistance Program will probably be increased to cover a greater number of people in the ensuing years. Even though this should take place, we should strive to develop a more comprehensive Cancer Control Program.

GEORGIA REGIONAL MEDICAL PROGRAM

Last year the Georgia Regional Medical Program requested that the Committee on Cancer of the Medical Association of Georgia take over the functions of certain aspects of the Regional Medical Program because of cutback in funds. The Regional Medical Program requested that the Committee on Cancer assume the responsibility for the operation of the following ongoing projects, and we have continued to co-ordinate these activities.

The projects are as follows:

1. Project # 13, which include:
 - A. Area Cancer Facilities, now nine in number.
 - B. Cancer Workshops (Symposia or continuation of educational programs on various cancer topics).
 - C. Tumor Registries.

2. Project #30, the Augusta Radiation Therapy Center, the Committee on Cancer to act in an advisory capacity for the operation of this project.

The Committee again accepted the request of the Regional Medical Program to continue the operation of these projects. The Committee requested the participation of the Georgia Division of the American Cancer Society to participate in the professional education phase of the Program, and they have given us full co-operation.

The responsibility for fiscal management remains a function of the Georgia Regional Medical Program, but the co-ordination of the programs remains the responsibility of the Committee on Cancer of the Medical Association of Georgia.

In order for the Committee on Cancer to operate in a more efficient manner, we subdivided the Committee into subcommittees with a chairman of each as follows, thus forming an Executive Committee:

1. Tumor Registries
2. Area Cancer Facility Workshops
3. Area Cancer Facility Planning & Development (Augusta Radiation Therapy Center)

President Nixon is cutting back on some of the health funds and there is every indication that the GRMP on cancer will not be funded after June 30, 1973. GRMP has contributed vastly to cancer control in Georgia, and the loss of these funds will undoubtedly result in a decrease in the activities of cancer control.

"THE NATIONAL CANCER ACT OF 1971"

December 23, 1971, the Senate and House of Representatives of the U.S. Congress enacted "The National Cancer Act of 1971" with the proviso that \$400 million be appropriated for the fiscal year ending June 30, 1972; \$500 million be appropriated for the fiscal year ending June 30, 1973; and \$600 million be appropriated for the fiscal year ending June 30, 1974.

The Act authorizes the director of the National Cancer Institute, which will be located with the National Institute of Health, to plan and develop an expanded, intensified and coordinated cancer research program encompassing the programs of the National Cancer Institute, related programs of the other research institutes and other Federal and non-Federal programs, with the advice of the National Cancer Advisory Board.

Furthermore, cancer control programs shall be established as necessary for cooperation with state and other health agencies in the diagnosis, prevention and treatment of cancer.

As of January 25, 1973, we have received the following information: The National Cancer Institute is launching an extensive program of financial assistance for cancer control activities. There is \$30 million available for fiscal year 1973 and \$60 million is expected to be available in 1974.

There is no assurance that these funds will be available. However, a recent statement by the President, in his budget address to Congress concerning the curtailment of funds, said funds for cancer would be increased.

The Committee on Cancer has conferred with the Physical Health Division of the Department of Human Resources seeking ways and means of establishing a statewide cancer control program with all agencies in the diagnosis, prevention and treatment of cancer.

We have assurance from the Physical Health Division of their interest in and efforts toward developing a statewide comprehensive cancer control program to include cancer detection, cancer treatment and rehabilitation. They will assist us in every way in seeking funds for these programs. Actually we are going to need a sum of at least \$1.5 million to do the job. But we will have to spell out exactly what we have at the present time and what is needed in the future as this will encompass cancer detection, therapy and rehabilitation.

The funds for cancer control programs provided by the Cancer Control Section of Physical Health total only \$400,000 for 1973. There is no way at the present time that we can get these funds increased by the Appropriation Committee of the Georgia General Assembly.

However, there are indications that if we set up a comprehensive statewide cancer control program, these funds may be increased. At the same time, we plan to review cancer control in Georgia as to physical facilities and personnel engaged in cancer control.

It is interesting to note that only \$488,000 has been awarded to Georgia from the NCI for research, whereas states like Pennsylvania, California and Massachusetts have been awarded over \$7 million each.

Indicated below are the amounts of the Georgia Regional Medical Program money funded for expenditure for cancer in the past few years:

1970	\$374,000
1972	\$279,000
1973	204,000
Total	\$857,000

The Committee on Cancer has established rapport with the Chairman of the Commission of Human Resources and the Chairman of the Physical Health Division of the Board of Human Resources. All are aware of the financial struggle that we are faced with in Georgia for cancer control.

TUMOR REGISTRIES

The Committee on Tumor Registries of the Committee on Cancer of the Medical Association of Georgia has worked very hard in the past year in revising the protocol for use by the tumor registries. It is a condensed form but can be readily used with the Biometry Department of Emory University for tabulation of end results. All of the tumor registries that are participating in the Georgia Regional Medical Program are using this form.

We are going to be faced with the question of the continuation of the biometric studies that have been performed by the Biometry Department of Emory University under the support of the Regional Medical Program, and it is hoped that we can get funds that will continue the operation of this working relationship with the Department at Emory University.

All participating tumor registries have been updated since 1967, and we are now beginning to see the fruits of well-planned and organized tumor registries. This will give us adequate information for feedback to the physicians.

CANCER WORKSHOPS

The Subcommittee on Cancer Workshops has developed the following Programs:

1. "Chemotherapy and Immunology" March 16-17, 1973, at the Callaway Gardens, Pine Mountain, Ga.

2. "Gynecologic Cancer" April 14, 1973, at the Outpatient Clinic, John D. Archbold Memorial Hospital, Thomasville, Ga.

3. "Cancer of the Digestive Tract" October 12, 1973, at the Medical College of Georgia, Augusta, Ga.

These workshops have proved to be invaluable in the area of continuing education and disseminating information to physicians of the Medical Association of Georgia on various subjects in Cancer Control.

AREA CANCER FACILITIES

There are nine Area Cancer Facilities designated by the Regional Medical Program, but in the event that the Regional Medical Program should fail to be continued by an act of Congress, it is hoped that we will be able to develop these facilities by funds from other sources.

AREA CANCER FACILITY PLANNING AND DEVELOPMENT (AUGUSTA RADIATION THERAPY CENTER)

For more than four years, the Augusta Radiation Therapy Center has been developing extensive plans for radiation therapy covering a vast number of counties in the southeastern section of the state. The facility is in need of the necessary funds to develop this program, and it is hoped that funds for this project will be available through the National Cancer Act. It is possible that support may be received from another source.

REHABILITATION OF THE CANCER PATIENT

The Georgia Division of the American Cancer Society has been very active in the area of rehabilitation of the cancer patient: "Reach to Recover" and "Care of the Ostomy Patient." Many demonstrations and lectures have been held throughout the state at various cancer clinics on Reach to Recovery and the Ostomy programs. These have been very beneficial in creating interest in quality of survival and the restoration of the cancer patient back to normal activity.

The Committee on Cancer endorses this program and wishes to see that it continues and that there will be more interest and support of this by the physicians throughout the state.

THE ALBANY TUMOR CLINIC

The Albany Tumor Clinic requested provisional approval for re-opening of their clinic, and the Committee on Cancer gave a provisional approval for two years subject to the review by the American College of Surgeons within the next two years to survey their clinic.

HISTORICAL COMMITTEE

MILFORD B. HATCHER, M.D.

The Committee continues to work toward the establishment of a central location for the files and data concerning the history of the Medical Association of Georgia along with the compiling of a complete historical coverage of medicine in Georgia.

The Women's Auxiliary has agreed to work with the Historical Committee for the furnishing of the "Doctor's Cabin" at the Stone Mountain Memorial Park. Items of historical, medical interest, such as instruments, and all printed matter will be appreciated. No recommendations are made at this time.

COMMITTEE ON STATE LEGISLATION

HARRISON L. ROGERS, M.D.

The following is a summary of the legislation of interest to the Medical Association of Georgia considered during the 1973 Session of the General Assembly:

CHIROPRACTIC INSURANCE COVERAGE (H.B. 147): This bill titled "Freedom of Choice" would require all health and accident insurance policies to reimburse chiropractors for their services. Under this bill the insurance companies would be forced to include chiropractic services in every health policy sold. The insured would therefore be forced to purchase this coverage whether or not he wanted it, and the company would be forced to include it in your policy. The results of this legislation would be two-fold: The premiums on all health and accident policies would go up; and chiropractors would be labeled physicians in all health and accident policies. H.B. 147 received an adverse recommendation by the House Insurance Committee. The chiropractors, discouraged by the defeat of this bill in Committee, will push even harder in 1974 to try to enact the same type legislation.

CHIROPRACTIC MEDICAID (H.B. 858): House Bill 858 would expand the word "physician" under Medicaid to include chiropractic services whether furnished in the office, the patient's home, the hospital, a nursing home or elsewhere. Legislation of this type would unquestionably increase Medicaid payments, and in a short time probably force Medicaid into bankruptcy. The House Human Relations Committee will study this bill during the interim between the 1973-1974 legislative session. Medicine will definitely have to contend with H.B. 858 during the '74 General Assembly.

ABORTION (H.B. 915): This bill as originally introduced did not include what MAG desired in abortion legislation. The original bill passed the House of Representatives and went to the Senate; MAG had a substitute bill drawn and introduced in the Senate Health and Welfare Committee. This substitute bill passed the Senate and the House of Representatives, and upon the Governor's signature will become law. Simply stated, this bill requires all abortions to be performed by duly licensed physicians and after the first trimester all abortions must be performed in a licensed hospital or facility licensed by the Georgia Department of Human Resources. After the second trimester the physician and two consulting physicians must certify that said abortion is necessary in their best clinical judgement to preserve the life and health of the woman. In addition, any person who shall state in writing objections to any abortion or all abortions on moral or religious grounds shall not be required to participate in the procedures if it will result in such abortion. A copy of this legislation is available upon request through MAG Headquarters.

CERTIFICATE OF NEED (H.B. 504): This bill would require anyone who wishes to build or substan-

tially enlarge a hospital or nursing home to obtain a certificate of need from the State before construction begins. As presently written MAG opposes such Certificate of Need Legislation and helped to defeat H.B. 504 in the Senate Health and Welfare Committee where it will be studied during the interim. If H.B. 504 could be altered to such a degree where all physicians would not be as drastically affected, MAG would support such legislation. However, at present, MAG is in opposition to the Hospital Association, the Nursing Home Association, the Department of Human Resources, and the Governor on this type Legislation.

HEALTH-WELFARE BOARDS MERGER (H.B. 360): This bill, originally designed to merge all county health and welfare boards into a single county level Human Resources Board, passed the House but was put in an interim study committee in the Senate EREG (Economy, Reorganization and Efficiency in Government). It remains a live bill and could be enacted on during the '74 Session of the Legislature.

BOARD OF DENTAL AND MEDICAL EXAMINERS (H.B. 92): This bill passed both the House and the Senate and will become law upon signature of the Governor. H.B. 92 will raise the current Per Diem allowances of \$25 a day plus mileage and expenses for the members of the Dental and Medical Board of Examiners to include payment of \$1500 per examination. Although this bill only affects 12 to 18 MAG members, MAG helped in its passage.

DRIVERS LICENSE ADVISORY BOARD (H.B. 21): This bill creates an advisory board to set and review standards for physical and mental capabilities for persons to operate a motor vehicle safely. This board would be made up of physicians dealing with eye diseases, other physicians and optometrists. This bill passed both the House and Senate and will become law upon the Governor's signature. Some law such as this handed down nationally had to pass the Georgia General Assembly this year in order for the Department of Public Safety to receive 10 per cent of its funds from the Federal Government. MAG did not approve the wording of H.B. 21 as well as who should constitute the board, but due to the National model, it was impossible to defeat H.B. 21 on those merits.

ALIEN RECIPROCITY (H.B. 650): This bill states any alien licensed in another state where Georgia has reciprocity can receive a Georgia license without taking another exam, if the reciprocal state has *equal* or *higher* qualifications for medical licenses. This bill will become law upon signature of the Governor.

HYPNOTISM (H.B. 370): H.B. 370 would prohibit the use of hypnotism except by physicians, dentists, and licensed psychologists. The effects of this bill will take hypnotism off the stage, and put it solely in the hands of professionals who know the implications and effects of hypnotism. This bill passed the House of Representatives and put in an interim study committee by the Senate Institutions and Mental Health Committee. MAG endorses this bill and tried unsuccessfully to get the Chairman of the Senate Institutions and Mental Health Committee to favorably pass it to the General Senate for vote. H.B. 370 will still have a chance in 1974 Session.

MEDICAL PRACTICE ACT (S.B. 387): This bill sponsored by MAG would define the term "Doctors of Medicine," "Licensed Doctors of Medicine," "Doctors

of Medicine Licensed to Practice in the State," and similar terms as meaning and including only those persons who have graduated from a medical college and hold the degree of Doctor of Medicine and who are also licensed to practice medicine under Chapter 84-9. The reason for S.B. 387 is to tighten the Medical Practice Act as to who Doctor of Medicine is and who shall use an M.D. behind his name. This bill passed both the House and the Senate and will become law upon the Governor's signature.

PROFESSIONAL HEALING ARTS LICENSURE—ACCREDITATION (H.B. 699): MAG sponsors this legislation which would require any applicant for a license to practice medicine, dentistry, osteopathy, podiatry, optometry, or chiropractic in this state, be a graduate of a school or college that is accredited by an accrediting agency that is recognized and approved by the National Commission on Accrediting or the Office of Education, U.S. Department of Health, Education and Welfare. This bill in no way will affect anyone presently licensed and practicing in Georgia. H.B. 699 has an effective date of 1979 to give the chiropractic schools (the only profession that is not accredited by either of these organizations) ample time to upgrade the caliber of their schools to become accredited and through their own publication they have stated this would be impossible. H.B. 699 passed the House Health and Ecology Committee and is now in the House Rules Committee. After deliberation between MAG and various representatives it was decided to leave H.B. 699 in the Rules Committee this year. The very first day of the 1974 Session H.B. 699 goes back to the Health and Ecology Committee and reintroduced for the 1974 Session.

With this additional time, it is hopeful that all physicians and interested parties in Georgia will contact their representatives and Senators during the next nine months to encourage their support for this legislation which will upgrade the health care available for every citizen in Georgia.

THANK YOU: Due to the efforts of many MAG members, the 1973 Session was extremely favorable. I personally want to thank you for the time, money, and effort each of you put forth this year. It was extremely helpful and the results are obvious. All Legislation that was not defeated this year or remains in a study committee is still a live piece of legislation and will be considered again next year. During the summer months it is extremely important that you contact your representatives and senators informing them of your wishes and desires concerning the passage or defeat of specific legislation. If you need any additional information or would like a copy of any legislation, please contact MAG Legislative Representative Mr. Rusty Kidd, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

COMMENDATIONS: Your legislative committee started this year with "fresh troops in the trenches." As you are aware, Mr. Moffett was elevated last year and subsequently Mr. Rusty Kidd was employed to handle legislative affairs. His job performance has been excellent for with only a brief introduction, Mr. Kidd was able to capably represent our views at the Capitol. Furthermore, he has done a splendid job of communicating with MAG membership and the Auxiliary.

Mr. Kidd would have found his task much more dif-

ficult without the dedication and talent of Dr. James Kaufmann, who donated far more of his time to legislative affairs this year than we could expect. Our MAG field men, Mr. Bailey and Mr. Carpenter, were on hand as well and added to the success of our legislative efforts. Each of these men deserve our sincere thanks.

COMMITTEE ON NATIONAL LEGISLATION

J. FRANK WALKER, M.D.

During the past year your Committee has followed with great interest legislation in the Congress that would have appropriated varying amounts of "start-up" money for a vast network of health maintenance organizations (contract practice) as well as legislation ultimately enacted authorizing professional standards review organizations (PSRO) throughout the country. This latter bill, H.R. 1 in the 92nd Congress, also provided for limited inclusion of chiropractic services under Medicare. These two items are discussed separately as follows:

HEALTH MAINTENANCE ORGANIZATIONS: The HMO Bill which attracted the most attention during the 92nd Congress was S-3327 introduced by Senator Edward Kennedy. The Bill, which carried a \$5 billion price tag, would have established HMO's as the dominant form of health care delivery in the nation, and would have superseded state laws (including Georgia law) which presently restrict the development of prepaid health care delivery systems.

Senator Kennedy has reintroduced this bill and at the time this report is written (3-23-73) it appears probable that it will again pass the Senate.

In the lower House, a bill, H.R. 51 by Congressmen Rogers of Florida and Roy of Kansas, would authorize the expenditure of \$345 million to test the capability of HMO's over a three-year period.

In support of the much milder administration HMO bill (\$60 million), HEW Secretary Weinberger stated there is no long-term commitment to HMO subsidies and that federal aid would be terminated if HMO's failed to compete with other delivery modes.

PSRO: The enactment of the PSRO provision of H.R. 1 is potentially the most significant medical legislation ever adopted at the federal level. PSRO mandates by federal statute the compulsory development of local review organizations to monitor all institutional medical services provided under federally funded health programs. The prime PSRO characteristics are:

(1) The expense of Professional Standards Review Organizations will be underwritten by HEW.

(2) PSRO's must provide for open membership to both M.D.'s and osteopaths. They may not require membership in or the payments of dues to any medical society as a condition for joining PSRO, nor may there be any restriction on who may serve as an officer in PSRO.

(3) The HEW Secretary will designate PSRO areas throughout the United States by January 1, 1974. Until 1976, however, only organizations representing substantial numbers of physicians in a particular area can be designated as a PSRO.

(4) PSRO's must be non-profit organizations or a component part of a non-profit organization.

(5) They must be able to demonstrate their professional competence to review appropriate professional services.

(6) Physicians' organizations are to be given priority in the establishment of PSRO's. If no physician organization exists, or is unwilling to assume this role in a given area, the HEW Secretary, after January 1, 1976, can designate a qualified public or non-profit organization to serve as the PSRO.

(7) PSRO's must use only M.D.'s and D.O.'s to review actions of their peers.

(8) PSRO's initially will be required to review only institutional care. As soon as possible, however, they will be expected to review the professional activities of physicians and other health care practitioners as well as institutional and non-institutional providers of services under programs paid for by Medicare, Medicaid, and Maternal and Child Health Programs.

(9) PSRO's will determine whether services are medically necessary; whether the quality of care meets professionally recognized standards; and whether or not the service was performed in an appropriate facility.

(10) There will be a structured appeals mechanism from decisions made by PSRO's.

(11) Data gathered by PSRO's is to remain confidential.

CHIROPRACTIC SERVICES UNDER MEDICARE: H.R. 1 of the 92nd Congress provides that chiropractic treatment by manual spinal manipulation to correct a subluxation demonstrated by an X-ray to exist, will be a covered service under the Medicare program. Exactly how chiropractors will fit into the Medicare program is a matter that Congress elected to leave to regulations to be promulgated by the Secretary of the Department of Health, Education and Welfare. As of the date that this report is written, no regulation has been promulgated by the Secretary. When such regulations become available, they will be analyzed with great care.

COMMITTEE ON MEDICINE AND RELIGION

W. H. POOL, JR., M.D.

The Medicine and Religion Committee had its first breakfast meeting for the general membership and their wives at the annual meeting of the Medical Association of Georgia in Macon on Sunday morning, May 7, 1972. The program of the meeting is enclosed. There were approximately 45 in attendance. A lively discussion was held at the completion of the presentations by associate professor of religion, Ray Brewster and Dr. M. D. Pittard of Toccoa, reactor. It was the feeling of those present that this was a worthwhile interchange.

The meeting of the Medicine and Religion Committee at the fall Conclave was held with representatives of the theological seminaries. We discussed their needs in areas of medicine and religion, as well as their contributions to the schools of medicine. This is considered an initial contact with further dialogue expected to ensue in coming years.

The decision was made to continue the general breakfast meeting in association with the annual meeting of MAG in Augusta. The program for this year's breakfast will be presented by the Department of Humanities at the Medical College of Georgia. We plan a dialogue with physicians attending concerning the type problems they have encountered for which such

a department in a medical school might have helped prepare them. We anticipate a practical discussion.

The Chairman of the Medicine and Religion Committee has served several program committees with resource material as they have developed individual programs in areas of medicine and religion.

In the recent reorganization of the AMA, the Committee on Medicine and Religion was abolished, although the Department of Medicine and Religion remains. The Southeastern Workshop of Chairmen of Medicine and Religion State Committees was, therefore, extremely important. We discussed the functions of the department in the AMA setting. It was our unanimous opinion that the department should be strengthened rather than diluted and that this significant area of contribution through the AMA has been and should continue to be one of the best public relations assets we have. We are attempting to help give direction and work toward ways of giving support that will result in a stronger department with a much broader base of physician support.

I would like to take this opportunity to thank the members of the committee and others in the state for their active support of the concerns of our committee. There have been several seminars, notably those co-sponsored by the Cobb County Medical Society and another one at the Medical College of Georgia.

COMMITTEE ON OCCUPATIONAL HEALTH

TOM HOWELL, M.D.

The Committee on Occupational Health has been primarily concerned with assisting industry to realize and meet its obligations under the Occupational Safety and Health Act. A member of the committee recently testified before the Legislative Committee of North Carolina and of Georgia regarding noise in industry. The Chairman is presently serving as consultant for the new rehabilitation program in Georgia; this program utilizes Workmen's Compensation Funds and Office of Rehabilitation Services. A program for respiratory evaluation is being finalized to assist industry in meeting its requirements for workers exposed to asbestos.

The Committee has no recommendation for consideration by the House.

COMMITTEE ON PRIVATE PRACTICE

W. DANIEL JORDAN, M.D.

The Committee on Private Practice met during the annual committee conclave in August of 1972. At that time a discussion was held concerning several subjects including certificate of need legislation, HMO legislation, and the definition of private practice.

The Committee recommended to the Executive Committee of Council that MAG explore the possibility of establishing a liaison committee to include representatives from MAG, GHA, and GNHA that would give advice and counsel to any organization within the state concerning the construction of a new hospital or expansion of existing facilities. It was pointed out that this would serve entirely as a recommending or advisory agency with no distinct powers. Although there was considerable opposition to the concept of certificate of need legislation, the above recommendation was felt to be an alternative approach to this type of legislation.

HMO legislation was discussed briefly, and it was planned that representatives of the Private Practice Committee would meet with representatives of the Legislative Committee to discuss the development of a position of MAG on possibly upcoming HMO Legislation. This joint meeting was held in September 1972 and various recommendations concerning HMO legislation were drawn at that particular meeting. This was then presented to the Executive Committee of Council in its September 1972 meeting. A minority report was also presented to that same meeting stating opposition to the Medical Association of Georgia presenting any recommendations to the State Legislature concerning proposed HMO legislation.

Further discussion at the August meeting was held on the definition of private practice, and though a definitive conclusion was not reached, it was felt that private practice would include at least three basic principles, these being: (1) personalized medical care, (2) fee for service, (3) freedom of choice by physician and patient.

An additional matter referred to this committee since the last committee meeting concerned the question of compensation to individual physicians for services performed as members of Utilization Review Committees. This matter is currently under discussion by the Private Practice Committee.

The Private Practice Committee feels that our current form of practice of medicine has been the mechanism by which the medical care of our country has achieved its current high standards. For this reason, this committee would continue to explore methods of strengthening this concept of private practice of medicine, being aware of the multiple attempts at placing coercive controls upon the private practitioner and other attempts to allow monopolistic and discriminatory policies to invade the delivery of medical care. We continue to maintain that the pluralistic system should allow for the free development of all forms of medical care and that this should be accomplished without the use of legislation or controls that would stifle competition.

SCHOOL CHILD HEALTH COMMITTEE

FRED L. ALLMAN, M.D.

The function of the School Child Health Committee of the Medical Association of Georgia during the past year as in previous years has been to stimulate cooperation by individual physicians and the school child health program, to keep the profession informed of the school health program, and to report to the profession on the progress. Our committee has continued to try to improve its relationship with the Dental Association, the public school system, the Health Department, parents groups, Georgia High School Coaches Association, and other appropriate organizations. Specifically, the committee has accomplished the following during the past year.

1. FOLLOW-UP ON EXISTING PROJECTS

a. *Smoking and Health*: The teacher resource kits which were placed in the schools in 1967 in cooperation with the State Department of Education and the Georgia Heart Association, The Georgia Tubercular Association, the Georgia Cancer Society, and the State

Health Department have continued to be utilized in many schools throughout Georgia and have been used as a model for other states.

b. *Post-graduate Course:* The Medical Association of Georgia, through the Committee on the Medical Aspects of Sports and the School Child Health Committee, again sponsored a post-graduate course on the medical aspects of sports. Members of the committee, other members of the Medical Association of Georgia, athletic trainers from the University of Georgia and Georgia Tech, presented a very interesting and worthwhile program in Atlanta, Ga., last August. Again, the highlight of the meeting was a luncheon which was co-sponsored by the Health Department under the supervision of Mrs. Mary Helen Goodloe and the Coca-Cola Company. More than 100 coaches and physicians attended the luncheon and participated in an informal discussion on "Nutrition for the Athlete."

c. *News Release:* A news release was sent to all of the news media throughout the state in August concerning the safe methods of conducting athletic practices and events in hot, humid weather. This item received very good distribution and helped to prevent heat deaths in the state last year.

d. *Pre-school Screening of Vision and Hearing:* This has become a reality. As approved by the Medical Association of Georgia in previous session, the Board was established consisting of two representatives of the Georgia Society of Otolaryngology, two representatives of the Georgia Society of Ophthalmology, one representative from each of the two medical schools, two representatives of the Medical Association of Georgia and a representative of the Medical Advisory Committee of the Georgia Society for the Prevention of Blindness. Upon the recommendation of this group, each county medical society in the state of Georgia has been asked to name a chairman for pre-school screening of vision and hearing. Many of the societies have complied with this request and many counties have moved forward with pre-school screening of vision and hearing. It is hoped that in the future each and every county will have such a chairman and will have active programs for this very worthwhile activity.

e. *Round-Robin Seminars:* The first of the proposed Round-Robin Seminars on the Medical Aspects of Sports was held in Augusta, Ga., last year. The response was very good and the local chairman, Dr. Graham, is to be commended for his efforts in making that program a success. It is hoped that in the future other programs of a similar nature in different sections of the state will also be held.

2. OLD PROJECTS NOT YET COMPLETED

a. *School Benefit Plan:* The committee continues to feel that there is need for an improved program for financing the care of the injured athlete. This is a problem that directs itself to the medical profession, the involved schools, and to the parents as well as the athlete. The goal should be adequate insurance coverage for each and every athlete participating within the state of Georgia.

b. *The Certification of Coaches:* The certification of coaches, with minimum standards of instruction in important subjects such as first aid and other preventive measures, continues to be an important item on our agenda of things that must be accomplished. Also, a

criteria of certification for physicians for attendance at athletic events must be given consideration.

c. *New Comprehensive Form for Pre-Participation Physical Evaluation of Athletes:* A new, comprehensive form for pre-participation physical evaluation of athletes has been completed. It now becomes the task of this committee to see that the material is printed and disseminated to those who can offer this to their athletes as a much improved method of evaluation. This evaluation is primarily designed to evaluate the physical readiness of an individual for sports. Tests including cardiorespiratory fitness, body build, strength tests, measurements of flexibility and indications of physical maturation are included.

In concluding, the committee would like to encourage each member of the Medical Association of Georgia to help develop the integrated relationship of health and education. There can be no question that one needs to be educated in order to develop and protect one's health and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician of Georgia.

AD HOC COMMITTEE TO STUDY
MEDICAL DISCIPLINARY LAWS

C. E. BOHLER, M.D.

The Ad Hoc Committee to establish a Medical Disciplinary Board has met once and will meet again prior to the Annual Session of Medical Association of Georgia.

Members of this Committee other than the Chairman are Robert Wells, C. H. Richardson, Thomas Sappington, Albert M. Deal and William Morton. Doctors Deal and Morton are members of the Composite State Board of Medical Examiners and Dr. Morton is Chairman of the Composite State Board.

Plans for a disciplinary board are being formulated with the approval and full cooperation of the Composite State Board of Medical Examiners and the disciplinary board will function within the framework of the Medical Practice Act of the State of Georgia.

Final plans will be drawn after we receive written approval from the Attorney General of Georgia for establishment of a disciplinary board that can function without fear of prosecution for libel while conscientiously investigating disciplinary problems and we must have the Attorney General's assurance that this proposed board will have legal authority to investigate disciplinary problems that may arise.

We will have final plans for presentation to the House of Delegates in May.

Speaker Rogers then proceeded with unfinished business calling for submission for supplemental reports from officers, councilors and committee chairmen.

Supplemental Report 73-1: Ad Hoc Committee to Study Medical Disciplinary Laws—*Reference Committee C*

Supplemental Report 73-2: Committee on Emergency Medical Services—*Reference Committee A*

Supplemental Report 73-3: Interspecialty Council—*Reference Committee B*

Supplemental Report 73-4: Communications Committee—*Reference Committee D*

Supplemental Report 73-5: Constitution and Bylaws Committee—*Reference Committee C*

Speaker Rogers continued with new business calling for the introduction of resolutions and requested that the resolved portion only be read to the House. The following resolutions were then presented:

Resolution 73-1: Osteopathic Membership in MAG—*Reference Committee C*

Resolution 73-2: Professional Standards Review Organization—*Reference Committee B*

Resolution 73-3: Professional Standards Review Organization—*Reference Committee B*

Resolution 73-4: Professional Standards Review Organization—*Reference Committee B*

Resolution 73-5: Professional Standards Review Organization—*Reference Committee B*

Resolution 73-6: Newborn Insurance Coverage—*Reference Committee C*

Resolution 73-7: Recomposition of Council—*Reference Committee D*

Resolution 73-8: Anti-Substitution Laws—*Reference Committee C*

Speaker Rogers then thanked all those members serving on Reference Committees, on the Credentials Committee and on the Tellers Committee. He announced that the business of the First Session of the House of Delegates had been completed and that the House would stand adjourned at 12:45 p.m. and would be reconvened for the Second Session on Sunday, May 13, 1973 at 9:00 a.m. The Speaker then turned the gavel over to First Vice President Braswell Collins to convene the special General Assembly program.

ROBERT DANIEL WALTER: THE PHYSICIAN BEHIND THE AWARD

Robert Daniel Walter, a Calhoun doctor who has served his community through civic clubs, scouting and church activities in addition to his 36 years of medical practice, was named Family Physician of the Year during the 119th Annual Session.

Dr. Walter was born in Wheeling, W.Va., and attended West Virginia University and Emory University medical schools. He interned in West Virginia, then began solo practice in that state. Following his marriage to Margaret Caroline McClain, Dr. Walter moved to Calhoun, joining two other doctors in practice. The Walters have three children and seven grandchildren.

A mainstay of the Georgia Academy of Family Physicians, Dr. Walter has served as its president and chairman of the board of directors. He is a fellow of the American Academy of Family Physicians and has been

a delegate and alternate delegate to AAFP meetings for 13 years. Dr. Walter serves on the Rural Health Committee for the Medical Association of Georgia.

As a citizen of Calhoun, Dr. Walter has served a term on the city council, as a member of the recreation committee, and as past president of the Junior Chamber of Commerce, charter member and past president of the Rotary Club, member of the American Legion, Elks Club and Chamber of Commerce.

Scouting has played a prominent part in the physician's life. He is a member of the Northwest Georgia Council Executive Committee and has served as a representative to the National Council of Boy Scouts for several years. He is a recipient of the Silver Beaver Award. Dr. Walter has been elder and clerk of the session of the Presbyterian church to which he belongs.



Saturday's panel on "Medical-Legal Problems" brought Geoffrey T. Mann, M.D. (picture at left), chief medical examiner for Broward County, Florida. Joining him is Sidney B. Weinberg, M.D. (above, right), medical examiner for Suffolk County, N. Y., who arranges his slide presentation with the help of MAG field representative Wallie Carpenter. Moderator is Herman D. Jones, M.D. of Atlanta (above, left), former director of the State Crime Laboratory.

MAG General Assembly Calhoun Lectureship

119th Annual Session of the Medical Association of Georgia
Friday, May 11, 1973

THE GENERAL ASSEMBLY of the 119th Annual Session of the Medical Association of Georgia was called to order by First Vice President Braswell Collins, Macon, at 12:45 p.m., in the Embassy Room of the Richmond Hotel, Augusta, Ga. on Friday, May 11, 1973.

Dr. Collins announced that we have assembled to hear the Calhoun Lectureship and called upon Dr. Preston D. Ellington, chairman of the Annual Session Committee, to introduce the Calhoun lecturer to the General Assembly.

Dr. Ellington presented Dr. James W. Turpin, founder and international director of Project Con-

cern, pointing out in his introductory remarks that Dr. Turpin was a graduate of the Emory University School of Medicine, was the recipient of many awards and honors, and had directed his unique organization to help overcome health problems in both international and domestic problem areas.

Following Dr. Turpin's presentation, Dr. Collins closed the General Assembly meeting with a reminder that there would be a program at 2:00 p.m. entitled, "Is There a Crisis in American Medicine?" Dr. Collins then adjourned the General Assembly at 1:20 p.m.



James W. Turpin, M.D. (L), international director of Project Concern delivers the Calhoun Lectureship, "Before the First Shot." Gladys Upshaw of Atlanta (R), regional secretary for Project Concern, explains the goals of the organization to an interested physician from her booth in the exhibits section.

MAG Annual Banquet

119th Annual Session of the Medical Association of Georgia

Saturday, May 12, 1973

THE ANNUAL BANQUET of the 119th Annual Session of the Medical Association of Georgia was held in the Embassy Room of the Richmond Hotel, Augusta, Ga., following a reception sponsored by the Richmond County Medical Society.

The invocation was offered by Dr. Milton I. Johnson of Macon.

Following dinner, First Vice President Braswell Collins introduced those sitting at the head table as follows: President-Elect and Mrs. C. E. Bohler; Secretary and Mrs. Earnest C. Atkins; Mrs. Cliff Moore, Jr., president of the MAG Auxiliary, and Dr. Moore; Mrs. Erle E. Wilkinson, president of the Woman's Auxiliary to the Southern Medical Association; David A. Wells, Chairman of Council; Mrs. Daniel H. G. Glover, Richmond County Medical Society Auxiliary president, and Dr. Glover; MAG Auxiliary president-elect, Mrs. John G. Bates and Dr. Bates; Richmond County Medical Society president, Dr. Luther M. Thomas and Mrs. Thomas; Richmond County Medical Society Local Arrangements chairman, Dr. Menard Ihnen and Mrs. Ihnen; Richmond County Medical Society Auxiliary Local Arrangements chairman, Mrs. Stephen Mulherin and Dr. Mulherin; Mrs. Braswell Collins.

Dr. Collins acknowledged MAG's continuing interest in Georgia's two medical schools and then presented unrestricted grant monies in the form of AMA-ERF checks, raised by contributions from physicians and the Woman's Auxiliary during the preceding year. Dr. Collins presented the checks as follows:

To Dr. Arthur Richardson, dean of Emory University's School of Medicine, a check in the amount of \$6,015.08.

To Dr. Curtis Carter, dean of the Medical College of Georgia, a check in the amount of \$6,604.99.

Scientific Exhibit Awards

Dr. John N. McClure, Atlanta, chairman of the MAG Committee on Scientific Exhibits, announced the winners of the scientific exhibits as follows:

First Place—"Localized Excision in Dupuytren's Contracture"—C. Martin Rhode, M.D. and W. D. Jennings, Jr., M.D., Augusta, Ga.

Second Place—"Surgery for Coronary Heart Dis-

ease"—Thomas J. Yeh, M.D., James L. Alexander, M.D., and C. Walker Beeson, II, M.D., Savannah, Ga.

Third Place—"Surgery for Impending Myocardial Infarction"—W. D. Logan, M.D., W. C. Maloy, M.D., Darrell R. Caudill, M.D., and Richard T. Thio, M.D., Atlanta, Ga.

Golf Prizes

Dr. Collins called on golf chairman, Dr. Stephen Mulherin, to announce the winners of the golf tournament and present the trophies. The winners were:

Low Gross—Steve Mulherin (74)

Low Gross Runner-Up—Tie between L. Newton Turk and H. Hilt Hammett (84)

Low Net—Paul D. Mahoney (72)

Low Net Runner-Up—Tie between Jack Crumley, Luther Wolff and Alton V. Hallum, Jr. (73)

Closest to Pin (Thursday)—F. R. Miller

Closest to Pin (Friday)—W. R. Daniel

Tennis Prizes

Dr. Ronald F. Galloway, tennis chairman, was asked to announce the winners of the Tennis Tournament and make the presentation of prizes as follows:

Men's Singles Winner—Walker Harris

Men's Singles Finalist—John Angell

Women's Doubles Winner—Ann Galloway and Lois Ellison

Women's Doubles Finalist—Rebecca Thomas and Betty Sussman

Art Exhibit Prizes

Dr. Collins then recognized Mrs. William Fuller to announce the winners of the art exhibit and make the presentation of prizes as follows:

First Prize—Mrs. J. R. Hutchinson for a pastel portrait "Joe"

Second Prize—Mrs. John F. Josey for an oil painting "Under the Sea"

Third Prize—Mrs. J. Rhodes Haverty for a water color "Alhambra"

Children's Division

First Prize—Matthew Bohler, age 15, photography

Honorable Mention—Mark Minor, age 8

Medical Mile

Dr. Daniel F. Ward was then recognized to announce the winners of the Medical Mile as follows:



Marietta's Luther G. Fortson wins the Civic Endeavor Award.

Hardman Award winner, A. Hamblin Letton, M.D. (second from right) and his wife are congratulated by the former physician-governor L. G. Hardman and Mrs. Hardman.



First Place—Richard L. Benson, Douglas
Second Place—John Hagan, Atlanta
Third Place—Zach Kilpatrick, Augusta
Fourth Place—Gus McCravey

Civic Endeavor Award

Dr. Collins reminded the House of Delegates that MAG had created a special award to honor those physicians who dedicate a substantial amount of their time to civic activities. He then announced that the winner of the 1973 MAG Civic Endeavor Award was Dr. Luther G. Fortson of Marietta.

Hardman Award

Highlighting the awards ceremony, Dr. Collins

gave a brief history of the Hardman Cup and the physician-governor who made this award available for presentation through MAG. He then announced that the recipient of the 1973 Hardman Award was Dr. A. Letton of Atlanta. Dr. Letton was cited for his numerous contributions in the field of cancer.

At the conclusion of the awards ceremony, Dr. Collins symbolically passed the gavel to incoming President C. E. Bohler symbolizing the new leadership of the Association. In turn Dr. Bohler introduced the members of his family to the banquet assembled, and made a few brief remarks concerning his assumption of the presidency.

Dr. Collins then introduced the entertainment for the evening—the Wit's End Players.

HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

May 9, 1973

Budget: Recommended to Council approval of 1973-74 Budget of \$473,000 as submitted by Finance Committee.

AMA Survey Report: Approved establishing Ad Hoc Committee to study report with David Wells, M.D. as Chairman.

Ad Valorem Taxes: Approved challenging amount of ad valorem taxes levied on MAG Headquarters property.

Physician Commission to Nominating Board of Human Resources: Officially notified Governor of nomination of: Don Pittard, M.D., Toccoa; Henry Jennings, M.D., Gainesville; P. K. Dixon, M.D., Gainesville; Paul Bradley, M.D., Dalton; Tom Lumsden, M.D., Clarkesville—one to be appointed.

Committee for Protection of Human Subjects: Established Committee to assure adequate safeguards for confidentiality of patient records in data collection projects of EMCRO.

Membership Promotion: Approved mailing to solicit new members for MAG. Also, directed staff to develop informational brochure on benefits of MAG membership.

PSRO: Received report of legal counsel on articles of incorporation and bylaws for PSRO of Georgia. Deferred consideration until Executive Committee members had an opportunity to fully review these items.

Next Meeting: MAG suite, Americana Hotel, New York City, 12:00 Noon, June 25, 1973.

MAG General Session

(Second General Business Session)

119th Annual Session of the Medical Association of Georgia
Sunday, May 13, 1973

THE SECOND GENERAL SESSION of the 119th Annual Session of the Medical Association of Georgia was called to order Sunday, May 13, 1973 by First Vice President Braswell Collins of Macon at 9:00 a.m. in the Embassy Room of the Richmond Hotel, Augusta, Ga.

Dr. Collins opened the meeting with the traditional reading of the memorial list of those colleagues and wives of colleagues who had died since the 1972 Annual Session as follows:

Alfred M. Battey, Augusta, January 18, 1973
Charles R. F. Beall, Atlanta, July 12, 1972
Edgar Boling, Atlanta, July 28, 1972
Robert A. Clark, Jr., Macon, March 6, 1973
W. S. Cook, Albany, December 23, 1972
R. Carter Davis, Sr., Atlanta, May 6, 1973
George Dillinger, Thomasville, April 15, 1973
H. L. Dismuke, Ocilla, January 30, 1973
M. T. Edgerton, Atlanta, June 2, 1972
John Davis Elder, Athens, March 5, 1973
F. N. Gibson, Thomson, November 1971
L. H. Goldsmith, Athens, August 10, 1972
Ira Goldberg, Augusta, April 29, 1973
Henry W. Grady, Columbus, May 9, 1972
C. W. Harvey, Hogansville, December 25, 1972
Charles W. Hock, Augusta, June 11, 1972
L. W. Kaul, Athens, July 4, 1972
G. Lombard Kelley, Augusta, October 24, 1972
Joseph E. Lever, Sandersville, November 13, 1972
Charles G. Luther, Jr., Augusta, February 7, 1972
Thomas E. McGeachy, Decatur, January 5, 1973
Floyd W. McRae, Atlanta, August 28, 1972
W. O. Martin, Jr., Atlanta, April 9, 1973
W. E. Matthews, Augusta, June 18, 1972
J. Hubert Milford, Hartwell, October 26, 1972
James M. Miller, Augusta, April 23, 1972
John W. Mobley, Thomasville, May 17, 1972
D. F. Mullins, Augusta, February 2, 1973
Martin T. Myers, Atlanta, March 16, 1973
Emory R. Park, LaGrange, July 1, 1972
William M. Pavlovsky, Atlanta, June 4, 1972
R. C. Pendergrass, Americus, November 11, 1972
A. M. Phillips, Sr., Macon, April 9, 1973
E. A. Rosen, Dalton, October 22, 1972
Leonard R. Rue, Atlanta, July 11, 1972
S. C. Rutland, Atlanta, July 2, 1972
H. Ansley Seaman, Waycross, May 26, 1972
Richard C. Shepard, Jr., LaFayette, June 10, 1972
John N. Sherouse, Lavonia, June 16, 1972

J. G. Standifer, Blakely, November 20, 1972
Oscar R. Styles, Sr., Cedartown, April 24, 1972
Dallas Norman Thompson, Elberton, January 27, 1973
J. T. Vansant, Villa Rica, November 24, 1972
C. D. Vinson, Lizella, September 8, 1972
R. A. Vonderlehr, Atlanta, January 28, 1973
C. B. Welch, Attapulgus, June 27, 1972
Cecil White, Jr., Augusta, April 6, 1973
Clarence Hill Willis, Jr., Augusta, February 1, 1973
J. N. Willis, Columbus, August 12, 1972
Leonard W. Willis, Sr., Bainbridge, May 28, 1972

Auxiliary Deceased Members

Mrs. B. L. Bridges, Thomaston
Mrs. W. Devereaux Jarratt, Macon
Mrs. Ben Gilbert, Gainesville
Mrs. George Hall, Roswell
Mrs. J. Lon King, Macon (Past President WAMAG)
Mrs. William H. Lippitt, Savannah
Mrs. Glenn McCormick, Atlanta
Mrs. Robert C. McGahee, Augusta
Mrs. Francis M. Martin, Shellman
Mrs. Charles L. Ridley, Macon
Mrs. Everett Sanderson, Augusta
Mrs. N. R. Thomas, Albany
Mrs. David C. Williams, Macon

Dr. Collins then recognized H. Richard White, Rabbi of the Walton Way Temple, Augusta, for the purpose of delivering the invocation and leading the Assembly in a brief memorial service.

Certificates of Appreciation

Dr. Collins then called on Secretary Earnest C. Atkins, M.D., to present the MAG Certificates of Appreciation to individuals deserving of special recognition for their contributions to medicine as follows:

F. William Dowda, M.D., as MAG president 1972-73; Braswell E. Collins, M.D., as MAG first vice president 1972-73; C. E. Bohler, M.D., as First District councilor 1961-73; Joseph T. Christmas, M.D., as Third District councilor 1966-73; L. S. Bodziner, M.D., as Georgia Medical Society vice councilor 1970-73; Henry S. Jennings, M.D., as AMA alternate delegate 1968-73; Hoke Wammock, M.D., as chairman MAG Committee on Cancer 1965-73; F. G. Eldridge, M.D., as chairman MAG Committee on Communications, 1971-73; A. S. Yochem, M.D., as chairman MAG Committee on Mental Health 1969-73; Mrs. Cliff Moore, Jr., as

president Woman's Auxiliary to the Medical Association of Georgia, 1972-73; Luther M. Vinton, Jr., M.D., as GaMPAC chairman 1970-73; F. G. Eldridge, M.D., as chairman MAG Woman's Auxiliary Advisory Committee, 1971-73; James A. Kaufmann, M.D., for outstanding service to health care legislation, 1972-73; Representative Harry Dixon, for outstanding service to health care legislation, 1972-73; Senator Frank E. Coggin, for outstanding service to health care legislation 1972-73.

Dr. Collins recognized H. Hilt Hammett, Jr., second vice president to present life membership certificates in the form of special gold membership cards to MAG life members as follows:

Herbert S. Alden, Atlanta; H. C. Atkinson, Macon; D. L. Burns, Valdosta; Amey Chappell, Atlanta; Gordon Chason, Bainbridge; C. E. Cunningham, Decatur; Feltz C. Davis, Macon; G. A. Duncan, Decatur; Edgar M. Dunstan, Decatur; Walter C. Earle, Atlanta; W. G. Elliott, Cuthbert; Thomas P. Findley, Atlanta; Major F. Fowler, Atlanta; R. M. Harbin, Jr., Rome; A. Worth Hobby, Atlanta; John C. Ivey, Clarkeston; Montero Y. Levy, Atlanta; B. G. Owens, Valdosta; Edgar R. Pund, Seneca, S.C.; David E. Quinn, Dublin; Leonard J. Rabhan, Marathon, Fla.; Joseph C. Read, Atlanta; J. Harry Rogers, Atlanta; Fred F. Rudder, Atlanta; Cyrus H. Stoner, Atlanta; D. O. Thompson, Atlanta; D. Lloyd Wood, Dalton; Edward S. Wright, Atlanta; George W. Wright, Augusta.

Fifty Year Pins and Certificates

Dr. J. Rhodes Haverty was asked to present the 50-Year Certificates and Pins to those members who were graduated from medical school and licensed to practice medicine 50 years ago. They were:

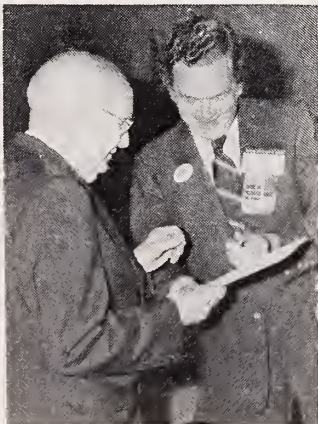
John L. Elliott, Savannah; H. P. Harrell, Augusta; Marion E. Hubert, Athens; Clinton G. Kemper, Atlanta; William V. Long, Savannah; James C. Metz, Savannah; Robert M. Paty, Oxford; Irvine Phinizy, Augusta.

GaMPAC Awards

Dr. J. Daniel Bateman, Albany, chairman of the Georgia Medical Political Action Committee, was recognized by Dr. Collins for the purpose of award-



Second Vice President Hilt Hammett presents a life membership card to Herbert S. Alden of Atlanta (L); H. P. Harrell of Augusta is one of eight to receive 50 Year pins from J. Rhodes Haverty (R).



Highest honor of the Medical Association, the Distinguished Service Award, goes to Luther H. Wolff of Columbus.



ing engraved plaques for outstanding contributions to the PAC movement in Georgia. The awards were:

Highest percentage of GaMPAC membership in a county medical society—Ogeechee River Medical Society, accepted by Dr. Leon Curry.

Highest percentage of GaMPAC membership in a congressional district—Fourth District, accepted by Dr. John Heard.

Largest total dollar contribution to GaMPAC—Medical Association of Atlanta, accepted by Dr. Edwin C. Evans.

Distinguished Service Award

Dr. Collins then stated that the highest honor that the Medical Association of Georgia could bestow in recognition of service to the Association was the Distinguished Service Award. He then announced that the recipient of the 1973 Distinguished Service Award was Luther H. Wolff of Columbus.

Future Annual Session Sites

Dr. Collins read the list of future Annual Session meeting sites as follows:

- | | |
|--------------------|---------------|
| 1974—Savannah | 1977—Macon |
| 1975—Atlanta | 1978—Augusta |
| 1976—Jekyll Island | 1979—Savannah |
| 1980—Atlanta | |

He then asked that the House defer until the 1974 meeting the selection of any additional Annual Session meeting sites in view of the fact that the format of the Annual Session may be changed thus making it possible for MAG to meet in many places now regarded too small.

Dr. Collins declared the Second Session to be recessed and turned the gavel over to Speaker Harrison Rogers to convene the Second Session of the MAG House of Delegates.

Second Session, House of Delegates

Sunday, May 13, 1973

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia, meeting in conjunction with the 119th Annual Session of the Association was called to order at 10:00 a.m. by Speaker Harrison L. Rogers, Jr., M.D. of Atlanta, in the Embassy Room, Richmond Hotel, Augusta, Ga.

Speaker Rogers called for the report on attendance and Dr. Timothy Harden, speaking for the Committee on Credentials, reported that over 40 delegates were present and accounted for, that a quorum was present and therefore the House could proceed with the business. The Speaker declared a quorum present and the House of Delegates to be duly in session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

Attendance

In a compilation of attendance taken from the official roll, 40 county medical societies were represented by their fully elected delegates or alternates. In total, 143 delegates were present at the Second Session. They were as follows:

BALDWIN: Pedro L. Tamayo; BARTOW: Richard A. Griffin, III; BEN HILL-IRWIN: George E. Mixon; BIBB: F. V. Kay, Jack F. Menendez, Beverly B. Sanders, J. G. Etheridge, C. G. Magnan, S. Charlotte Neuberger and G. C. Schlottman; OGEECHEE RIVER: Charles R. Richardson; BURKE: J. M. Byne; CARROLL-DOUGLAS-HARALSON: J. Larry Boss and Clark Robinson; GEORGIA MEDICAL SOCIETY: David E. Tanner, F. M. Johnston, Carson B. Burgstiner, J. A. Mulherin, Thomas A. Hetherington, J. Robert Logan, F. D. Maner and John Kirk Train; ELBERT: John B. O'Neal, III; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald L. Branyon, F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, F. Norman Bowles, Gary Palmer, Donald R. Rooney, James H. Manning, Charles Rey and W. C. Mitchell; COFFEE: Richard L. Benson; COLQUITT: John P. Tucker; COWETA: Lewis R. Collins; DEKALB: George W. Statham, L. L. Freeman, John Heard, Charles W. McDowell, L. C. Buchanan, Roy Vandiver, L. S. McGinnis, Timothy Harden, H. Duane Blair and Fred Amatrain; DOUGHERTY: Robert D. Waller, J. Daniel Bateman, Charles D. Hollis and D. M. Boyette; EMANUEL: Robert J. Moye; FLINT: Joe T. Christmas; FLOYD-POLK-CHATTOGA: James H. Smith, William D. Dooley,

Jack R. Meacham; FRANKLIN-HART: Robert F. Sullivan; MEDICAL ASSOCIATION OF ATLANTA: H. S. Ramos, John K. Schellack, William C. Collins, Frank L. Wilson, L. Newton Turk, III, Keith Quarterman, Harrison L. Rogers, John R. McCain, Robert L. Brown, James N. Brawner, III, Brown W. Dennis, Spencer Brewer, Jr., Charles E. Todd, Robert E. Wells, D. G. Whitney, Fleming L. Jolley, John T. Mauldin, Joseph Girardeau, C. R. Moorhead, A. J. Crumbley, John C. Hall, J. G. McDaniel, W. Dan Jordan, John S. Atwater, J. Rhodes Haverty, J. Frank Walker, A. A. Rayle, Jr., Armand Hendee, James A. Kaufmann, Alton V. Hallum, Jr., J. R. B. Hutchinson, Edwin C. Evans, William C. Waters, III, J. Harold Harrison, John McCoy, W. D. Logan, J. C. Ivey, Hugh D. Thompson and Thomas E. Whitesides; GLYNN: William J. Smith, Edwin A. Mayo and M. A. Glucksman; GORDON: R. D. Walter; HALL: Billy S. Hardman, Harvey Newman and Larry N. Durisch; PEACH BELT: Virgil W. McEver and W. E. Weems; JEFFERSON: C. Roy Williams; LAURENS: Robert Oliver and O. B. Johnson; MCDUFFIE: Thomas E. Averitt; MUSCOGEE: J. H. Deaton, James H. Sullivan, A. J. Kravtin, E. M. Molnar, Jack A. Raines and B. R. Maughon; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Stuart H. Prather, Jr., Julius T. Johnson, Luther M. Thomas, Jr., Ronald F. Galloway, Charles H. Wray, Preston D. Ellington, Walter L. Sheppard, Daniel B. Sullivan, J. Kenneth McDonald, Henry D. Scoggins, William E. Barfield, Carl Jelenko; SOUTH GEORGIA: William L. Dickson, Dewey Barton and Joe S. Stubbs; SOUTHWEST GEORGIA: Warren Baxley; SPALDING: James Skinner and J. L. King; STEPHENS: C. Peter Lampros; SUMTER: John H. Robinson; THOMAS-BROOKS-GRADY: Frank R. Miller and W. Trevejo; TIFT: M. B. Karsten; TROUP: H. Hilt Hammett and Joseph M. Almand; WALKER-CATOOSA-DADE: Ted D. Cash and Murphy K. Cureton; UPSON: T. A. Sappington; WARE: S. W. Clark and Floyd E. Davis; WAYNE: Ollie O. McGahee; WHITFIELD: James J. Oosterhoudt and Earl T. McGhee.

Speaker Rogers then reappointed the Teller's Committee necessitated by the absence of two of the members previously appointed. The new Teller's Committee consisted of Billy Hardman, Gainesville, chairman; Donald L. Branyon, Athens; and John Robinson, Americus. The Teller's Committee was then asked to distribute the ballots for the balloting of president-elect. As the ballots were being distributed by the Teller's Committee, Speaker Rogers instructed the House to vote for one candidate, either Beverly W. Forester or John Rhodes Haverty for

the office of president-elect. He then read the names of those candidates for other offices that were uncontested and instructed the Secretary to cast a unanimous ballot for this slate. These were:

- Second Vice President—Luther M. Thomas
- Vice Speaker—L. C. Buchanan
- AMA Delegate—J. W. Chambers
- AMA Delegate—John S. Atwater
- AMA Alternate—F. G. Eldridge
- AMA Alternate (Jennings unexpired term)—Luther M. Vinton, Jr.
- AMA Alternate (Full two-year term)—Luther M. Vinton, Jr.

At this point, balloting was conducted by the Teller's Committee.

Speaker Rogers then departed from his order of business to present to the House the president-elect of the American Academy of Family Physicians, Dr. James G. Price from Bush, Colo. Dr. Price expressed a few remarks of greeting.

Reference Committee Reports

Speaker Rogers called for reports from the Reference Committee chairmen. He reiterated the procedure to be followed stating that if no discussion or dissent followed each portion of the Reference Committee report, he would rule the item adopted as introduced. However, in the event that a Reference Committee amended a report or presented a substitute, the House should consider it the motion before the House. The Speaker explained that the Chair would rule each item adopted pending a final vote on the report as a whole at the conclusion of each Reference Committee report.

REPORT OF REFERENCE COMMITTEE A

Charles R. Richardson, M.D., *Chairman*

Chairman Richardson reported to the House that reports and resolutions referred to Reference Committee A had been considered by the Committee which met at 9:00 a.m. in the Walton Room, Richmond Motor Hotel, Augusta, Ga., on May 12, 1973. Members of the Committee present included: Charles R. Richardson, M.D., Statesboro, chairman; James H. Smith, M.D., Rome, vice chairman; Thomas A. Averitt, M.D., Thomson; James M. Skinner, M.D., Griffin; T. A. Hetherington, M.D., Savannah and Harold S. Ramos, M.D., Atlanta.

COUNCILOR OF COBB COUNTY MEDICAL SOCIETY

REMER Y. CLARK, M.D., *Councilor*
CHARLES R. UNDERWOOD, M.D., *Vice Councilor*

The expansion of hospital facilities including increase in available beds continues actively in Cobb County. Kennestone Hospital will shortly begin a \$13.6 million expansion designed over the next few years to provide

a completely new facility with an estimated 500-bed capacity. The county's other public facility—Cobb General Hospital—is rapidly completing major bed expansion plans. These two public hospitals have now come under the direction of a common hospital authority. Presently under construction in the county are two private facilities, each of approximately 150 beds, financed by private funds.

Again, Cobb County physicians wish to express thanks and gratitude to all members of the Medical Association of Georgia for their efforts and cooperation extended to Dr. W. C. Mitchell, recent Past President of the Medical Association of Georgia, during his term of office.

Cobb County continues to feel most appreciative of the efforts of the Woman's Auxiliary for their many contributions to the medical profession and the community. They contributed over \$20,000 for better patient care.

All council meetings have been attended by one or both of us representing Cobb County and have participated in its functions. The enrollment of the Society has increased to 201 members as of March 1, 1973. Of this number we have 182 Medical Association of Georgia dues paying members and 174 American Medical Association dues paying members.

The Cobb County Medical Society completely revised its Constitution and By-Laws in 1972 to reflect the needs of this rapidly enlarging Medical Society. It became necessary to increase the Cobb County Medical Society dues to \$100 a year due to the rapid growth of services offered to members.

Again this year the Cobb County Medical Society Medico-Legal Committee is pleased to report that the physicians will host the Cobb Bar Association. All local physicians and lawyers are invited as well as all local and state elected officials. Dr. Frank Walker, chairman, Medical Association of Georgia Medico-Legal Committee and Speaker for the American Medical Association House of Delegates, was our key speaker.

RECOMMENDATION

It has been recommended by the Executive Council of the Cobb County Medical Society that a resume of the Medical Association of Georgia Annual Meeting be mailed to delegates within two to three weeks after the Annual Meeting.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Cobb				
J. G. Palmer				
Marietta	180	169	182	174

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of the report of the Councilor of Cobb County Medical Society with additional recommendation as follows: "Highlights from the MAG Annual Session should now be mailed to the delegates and alternate delegates as well as officers, members of the MAG Council and Executive Committee and presidents and secretaries of the county medical societies."

HOUSE OF DELEGATES ACTION—Adopted the

Report of the Cobb County Medical Society Council with the additional recommendation contained in the Reference Committee report.

COMMITTEE ON ANNUAL SESSION

PRESTON D. ELLINGTON, M.D.

As the time has elapsed for the trial of the present format of the Annual Session, and after conversations and correspondence with other state medical association members and staff, it seems appropriate to consider another approach to the planning for the Annual Session.

Gradual decline in exhibitor interest has been indicated by fewer acceptances of the invitation to exhibit each year thereby reducing the income from exhibits. This disinterest is due to the fact that pharmaceutical companies prefer to exhibit at specialty society meetings where they contact the specialist who prescribes their products. Many of the companies prefer to contribute funds as an honorarium for guest speakers, which is less expensive for them than paying their representatives' expenses to staff their exhibit.

Having heard objections from some that too much has been planned in the present four-day format, a new format is recommended with the hope of approval so that it may become effective for the 1974 Annual Session:

(1) *Business Meetings* (Two and a half days):

First Day—House of Delegates, Reference Committees, President's Reception.

Second Day—Leisure time in a.m. for members, Reference Committee Reports Preparation, GaMPAC Luncheon, General Business meeting for memorial service, awards, election results and installation of officers.

Half Day—Second Session, House of Delegates, Adjournment at noon.

(2) *Scientific Sessions* would be separate from business sessions with the meetings held in resort areas outside the state or country. Exhibits will be eliminated but honorarium could be supplied by drug companies for guest speakers. Meetings could be scheduled for Friday, Saturday and Sunday mornings with afternoons free for relaxation. The scientific program can be planned many ways with specialty society participation, medical schools, etc.

A suggested time schedule for this format would be to hold business meetings in the spring and scientific meetings in the fall. One distinct advantage would be the increased availability of meeting facilities in the state due to the elimination of exhibits and the need for numerous meeting rooms. The members would derive more benefit from the improved scientific programs and the officers and delegates would be free to attend, having transacted the business of the Association at the business meetings in the spring. This schedule can be varied and other events scheduled, if desired.

RECOMMENDATION

Approval is sought for the division of business and scientific meetings of the Annual Session to become effective in 1974, with the details to be worked out by the Committee on Annual Session.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval

of the report with amendments and additional recommendations as follows:

(1) On Committee Report 73-1 between lines 30 and 31, Page 1 add “—and President's Banquet.” On Page 2 of the report the first sentence is changed to read as follows: “Scientific sessions would be separate from business sessions, and the meetings *could* be held in resort areas outside the state or country.”

(2) The recommendation is amended to read as follows: “Approval is sought for the division of business and scientific meetings of the Annual Session to become effective in 1974.”

(3) Additional recommendations are as follows: “That MAG Annual Business Meetings (and meetings of the House of Delegates) will continue to be rotated between locations as is presently being done.”

(4) That “Scientific sessions shall be held annually in Atlanta with a program coordinated through the Interspecialty Council and the Committee on Medical Education. The details of financing the Scientific Session shall be left to the Committee on Annual Sessions in regard to permitting exhibits or requesting honorarium or both.”

The Committee notes with regret that Dr. Preston Ellington declines reappointment to the MAG Annual Sessions Committee for the coming year and wishes to commend him for his untiring effort and diligent service over the past five years.

During the Committee's deliberation, the Committee noted the report of the Chairman of Council (Referred to Reference Committee B) dealing with the matter of separating the business meetings and the scientific meetings of MAG. Your Committee feels the recommendations above will take care of this matter.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Annual Session as amended by the Reference Committee.

COMMITTEE ON MATERNAL AND INFANT WELFARE

EUGENE GRIFFIN, M.D.

LIVEBIRTHS AND BIRTH RATE

There were 93,480 livebirths in 1971. The birth rate decreased to 20.0 (20.7 in 1970). This decrease in birth rate was due to a decrease of the white livebirth rate from 19.3 in 1970 to 18.2 in 1971. The non-white livebirth rate increased in the past year from 24.8 in 1970 to 25.2 in 1971. (Preliminary data indicates that there were approximately 90,000 livebirths in 1972.) Hospital deliveries reached a high of 97.5 per cent compared to a rate of 96.9 per cent in 1970. (In 1971, more than 9,000 hospital deliveries were paid for under Medicaid (Title XIX).)

MIDWIFE ACTIVITIES

There were 1,866 (two per cent) livebirths attended by midwives in 1971. This represented a decrease of 626 or 25 per cent less than the previous year.

MATERNAL MORTALITIES

There were 25 maternal deaths in Georgia in 1970 out of a total of 93,480 livebirths. The death rate of

2.7 per 10,000 livebirths represented a decrease from the 3.8 rate of 1970. The leading causes were hemorrhage (six), and abortion (four). Other causes were: infection, pulmonary embolus and other conditions or diseases of pregnancy or the puerperium (three each). Toxemia, ruptured uterus and other conditions during childbirth (two each); and ectopic pregnancy (one).

ABORTIONS

In calendar year 1972 there were 2,509 abortions reported to the Department of Human Resources. This amounts to about 28 abortions per 1,000 livebirths estimated for the year. It is noteworthy that up to January 31, 1973 there had been no "abortion" deaths reported for 1972. In 1971 Georgia had four maternal deaths related to abortion and six in 1970. This indicates that the number of criminally induced abortions are being reduced since abortion has become legalized in the state.

IMMATURE BIRTHS

In 1970 there were 8,215 immature livebirths (473 less than in 1969) for a rate of 87.9 per 1,000 livebirths (decrease from 90.9 in 1970). Immaturity at birth is twice as frequent in the nonwhite as in the white race. It is also significant that immaturity occurs more frequently in livebirths to the mother under 18 in both races.

Per Cent of Immature Livebirths—1969-1971

	1969	1970	1971
White	7.0	7.1	6.6
Nonwhite	14.1	13.4	13.0
White Under 18	9.9	10.0	9.1
White 18 to 39	6.8	6.9	6.4
Nonwhite Under 18	16.3	16.0	15.5
Nonwhite 18 to 39	13.7	12.9	12.4

BIRTHS TO UNWED MOTHERS

There were 11,337 livebirths to unwed mothers, an increase of 308 over the previous year. The rate rose from 115.4 to 121.3 between 1970 and 1971. Livebirths to white unwed mothers (2,057) decreased 361 and livebirths to unwed nonwhite mothers (9,380) increased 669 from the previous year. Immaturity at birth is significantly influenced by marital status both generally and racially.

LIVEBIRTHS TO GRAND MULTIPARA

A total of 4,564 livebirths (4.9 per cent) in 1971 were in the order of sixth and over, compared to 5,107 livebirths (5.4 per cent) in 1970. Since 1960 the per cent of first and second births to a mother has been increasing in both races. However, the per cent of births in the order of third or greater have shown sig-

STATE ABORTION REPORTING SUMMARY FOR GEORGIA, 1968 TO 1972
(Abortions reported in accordance with the Georgia Abortion Law)

	Year End Totals						Year End Totals				
	1968	1969	1970	1971	1972		1968	1969	1970	1971	1972
1. Number of abortions ..	73	168	701	1579	2509	8. Number of living children					
2. Number of live births .	87322	90195	95584	93480	90000	a. 0	20	81	299	646	1013
3. Deaths related to abortion	5	4	6	4	0	b. 1	7	34	99	254	496
4. Race						c. 2	20	23	113	273	414
a. White	69	147	569	1036	1244	d. 3	11	15	112	212	292
b. Black	3	21	133	538	1253	e. 4	8	7	46	90	155
c. Other	1	0	1	5	10	f. 5 or more	5	8	33	100	138
d. Unknown	0	0	0	0	2	g. Unknown	2	0	1	5	1
5. Age						9. Reasons					
a. Less than 15	4	5	32	64	124	a. Maternal physical health	16	23	60	217	55
b. 15-19	5	42	172	418	749	b. Maternal mental health	30	103	522	484	220
c. 20-24	12	41	161	429	705	c. Fetal deformity	24	29	36	34	24
d. 25-29	25	36	151	258	428	d. Rape or incest	3	9	12	10	8
e. 30-34	11	24	89	201	288	e. Contraceptive failure	0	1	9	71	7
f. 35-39	11	11	67	140	152	f. Social or economic hardship	0	0	58	743	2188
g. 40-44	4	8	28	64	57	g. Other	0	3	6	20	4
h. More than 45	0	1	3	5	6	h. Unknown	0	0	0	0	3
i. Unknown	1	0	0	0	0	10. Number of women who reportedly had sterilization procedure at same hospitalization	13	12	76	131	75
6. Weeks of gestation						11. Number of hospitals performing at least one abortion procedure	18	23	34	38	40
a. 8 or less	24	41	201	467	584	12. Number of counties with at least one resident abortion procedure	14	17	26	28	108
b. 9-12	27	68	327	713	1132	13. Number of physicians performing at least one abortion procedure	60	97	167	199	234
c. 13-16	13	26	74	162	303						
d. 17-20	6	17	82	224	465						
e. 21-24	1	3	16	8	23						
f. 25 or more	0	1	1	4	2						
g. Unknown	2	12	2	1	0						
7. Marital status											
a. Single	21	86	394	831	1420						
b. Married	52	74	309	571	841						
c. Separated	0	2	0	89	74						
d. Divorced	0	6	0	77	65						
e. Widowed	0	0	0	9	12						
f. Unknown	0	0	0	2	97						

Per Cent of Immature Livebirths—1969-1971

	1969	1970	1971
Married	8.6	8.3	7.9
Unmarried	14.4	14.5	14.1
White Married	6.8	7.0	6.5
White Unmarried	11.4	10.3	9.8
Nonwhite Married	13.6	11.2	12.1
Nonwhite Unmarried	15.2	15.6	15.0

nificant declines. In 1970, 28 per cent of all white births were in the order of third and greater. In 1971 this had declined to 27.4 per cent. The percentage of third and greater order livebirths among the nonwhite had declined from 39 per cent in 1970 to 37 per cent in 1971.

ADOLESCENT PREGNANCIES

Livebirths to adolescents representing 23.4 per cent of all livebirths in 1970 have increased to 24 per cent of all livebirths in 1971. There were 11,337 livebirths to mothers under 18 years of age out of the total of 22,443 adolescent livebirths. Of livebirths to unwed mothers, 54.8 percent were to adolescents. One out of every eight infants liveborn to an adolescent is immature by weight at birth.

PERINATAL DATA REPORTING

Because of the recommendations of the committee and the Medical Association of Georgia relating to medical information to be obtained with the birth certificate, the Department of Human Resources has studied methods of obtaining confidential medical data and adopted a new Certificate of Livebirth which will meet the needs for vital registration as well as medical biostatistical analysis. The new certificate was inaugurated in July, 1972.

FAMILY PLANNING

As of December 31, 1972, there were 67,000 women actively participating in the Department of Human Resources' Family Planning Program (1971—47,000). This number is based upon proven continuous active contraceptors by current records in the State data collection computerized evaluation system. The number is on the conservative side, as it does not include a large number of women who received services before the institution of the current record system and who may well be continuing as active contraceptors. During the fiscal year 1972 there was a total of 88,600 women served through 173,000 visits provided through Health Department clinics. Family planning services were provided to approximately 12,000 additional women through Medicaid. The greatest deterrent to more rapid expansion of this program has been the lack of sufficient physician time for services.

CERVICAL CANCER SCREENING PROGRAM

During fiscal year 1972 the Statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Human Resources provided pap smears to indigent and medically indigent patients receiving health services from local health departments for over 56,000 women. Since the beginning of the program in

1967, approximately 177,000 pap smears have been done, and a diagnosis of malignancy has been made in 384 cases. Eighty-six per cent of the malignancies were preinvasive carcinoma of the cervix. Treatment of diagnosed cases has been provided by state assisted tumor clinics and by private physicians.

NUTRITION

The release of the report of the Committee on Maternal Nutrition of the National Research Council highlighted the health nutritional needs of pregnant women, especially those of the teenager. New concepts relating to proper weight gain, the non-routine restriction of sodium intake, and the importance of folic acid with iron were emphasized. Copies of the Summary Report are available to physicians serving obstetrical patients from the Nutrition Consultant of the Maternal Health Unit of the Department of Human Resources. The Maternal Health Unit has implemented inservice training programs related to the recommendations of the report at local levels for health and education personnel who in turn extend proper nutritional guidance and education to patients.

Four-fifths of the counties in Georgia have food stamp programs, and the present trend is toward more wide use of food stamp programs. Consumer education is vitally needed throughout the State to improve the buying skills of homemakers in order that the use of food stamps provides for adequate nutrition.

RECOMMENDATIONS

1. Only four out of five of the counties in Georgia now have food stamp programs, and since nutrition of the expectant mother has proven to be a prime factor in the prevention of fetal prematurity and abnormality, the MAG urges the Governor to extend a food stamp program to the entire state irrespective of county lines.

2. That the MAG continue to urge physicians of the state to make available even more of their time in family planning programs especially to the indigent and medically indigent people of the state. This program is the very foundation upon which maternal and infant care of the state must depend.

3. That the MAG go on record as deploring the increase in incidence of livebirths in adolescent mothers (24 per cent of all livebirths in 1971—11,337 livebirths to mothers 18 and under). That members of MAG attempt to reduce this by family planning, sex education in the schools and all other means available.

REFERENCE COMMITTEE RECOMMENDATION
—The Committee recommended approval of this report with the exception of the last sentence on Page 9 which should be amended to read as follows: "That members of MAG attempt to reduce this by family planning, sex education in the schools, and all other appropriate means."

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Maternal and Infant Welfare.

COMMITTEE ON MENTAL HEALTH

A. S. YOCHER, JR., M.D.

The Medical Association of Georgia Mental Health Committee met formally on two occasions this past year with majority attendance.

The issues relative to sweeping changes in the directions and policies of the Division of Mental Health were challenged and recommendations made to and substantially approved by the MAG Executive Committee. Essentially, the committee deplored the rather arbitrary decisions and policy changes away from the leadership of sound psychiatric practices. Hopefully, the open discussions, and contacts with legislators will lead to a more cautious change to protect our citizens.

RECOMMENDATION

Retain committee size and representative membership.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of the Report on Mental Health.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Mental Health.

PHYSICIAN—LAWYER LIAISON COMMITTEE 1972-1973

J. FRANK WALKER, M.D.

The joint Medical-Legal Committee of the Medical Association of Georgia and the State Bar of Georgia continues in its attempts to mediate and/or arbitrate disputes arising between individual physicians and attorneys.

The joint committee met this year during the Committee Conclave August 13, 1972 at the Executive Park Motel, Atlanta, with a quorum present of both physicians and lawyers. Items discussed included individual problems between lawyers and physicians, as well as the feasibility of an arbitration panel in Georgia. The possibility of an arbitration panel for malpractice litigation is under continuing discussion. According to the legal research department of the American Medical Association, it seems premature to advocate arbitration as a solution to the liability problems of the medical profession. Such activity is being followed very closely.

During the year, the Chairman of the Committee participated in a symposium entitled "Medicine, Society and the Law in a Changing Era," sponsored by the Georgia Psychiatric Society, The Medical Association of Atlanta and the Emory University School of Law. The medical Chairman will also be a speaker this month at the Cobb County Medical Society meeting with the Cobb Judicial Circuit Bar Association.

RECOMMENDATIONS

Continue efforts to stimulate the formation of additional joint Medical-Legal Committees at local levels.

Continue to urge the development of additional presentations by or under the direction of the joint Medical-Legal Committee to local bar associations and/or county medical societies.

Continue to investigate the possibility of a Medical-Legal Panel to arbitrate professional liability suits.

Reprint "Principles Governing Physician-Attorney Relationships" as approved and adopted by the Medical Association of Georgia and the State Bar of Georgia as needed so that every physician in the state and every lawyer will have a copy readily available.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves the recom-

mendations included in the report of the Physician-Lawyer Liaison Committee.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Physician-Lawyer Liaison.

COMMITTEE ON RURAL HEALTH

IRVING D. HELLENGA, M.D.

The Committee on Rural Health initiated its work for 1972 by meeting in January at the Medical Association of Georgia, with the appropriate representatives of the Rural Health Advisory Committee, including representatives of the Extension Division, University of Georgia, as well as representatives of the Georgia Farm Bureau. Other Advisory Committee members were also present. Plans were made for the 1973 Annual Rural Health Conference, to be held at the Macon Hilton August 29 and 30, 1973. The theme will be: The Changing Role of State Government in Health and Environmental Protection. Lt. Gov. Lester Maddox will be among the participants, as will Mr. Richard Hardin of the Department of Human Resources.

In March, 1972 the Chairman attended the National Rural Health Conference in San Francisco, and was also in attendance at the State Chapter Chairman's Dinner.

In August, at the Committee Conclave, members of the Rural Health Committee were in attendance, with appropriate discussions involving the state and national conferences, as well as consideration of the new Health Access Stations. The presentation of the Health Access Stations, under the Georgia Regional Medical Program, was given by Dr. Tom Ross. Committee approval was given to those stations already set up.

On August 29 and 30, 1972, the Rural Health Conference in Macon was well attended by appropriate representatives of the Extension Division, Georgia Farm Bureau, representatives of 4-H, including the State Health winner and the State Safety winner, and other representatives of Health professions. There was an emphasis on legislation, with its close relationship to health care in this state. Representing the Medical Association of the program was Dr. Harrison Rogers.

Current plans for committee action for 1973 include attendance by the chairman, Dr. Hellinga, and the staff representative Carl Bailey at the National Rural Health Conference in Dallas, to be held March 28-30, 1973.

The Georgia Committee has hosted the regional meeting of AMA's Commission on Rural Health at the Regency in January, 1973. The committee has also visited the Health Access Station at Rochelle, Georgia, on the 28th of February.

RECOMMENDATIONS

That continued approval be given to the operation and program of the existing Health Access Stations.

That the work of the physician and lay members of the GRMP and its task forces be officially recognized and commended.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval with commendation of the report of the Committee on Rural Health.

**HOUSE OF DELEGATES ACTION—Adopted the
Report of the Committee on Rural Health.**

**COMMITTEE ON EMERGENCY
MEDICAL SERVICES**

CARL JELENKO, M.D.

The Emergency Medical Services Committee comprises: Drs. C. Jelenko, Augusta, chairman; J. B. Williams, Augusta; A. M. Rose, Marietta; J. C. Stubb, Valdosta; J. N. Berry, Atlanta; R. E. Wells, Atlanta; L. M. Vinton, Decatur; T. L. Ross, Macon; Z. B. Williams, Griffin; D. B. Hendrick, Atlanta; J. Oosterhoudt, Dalton; C. G. Magnan, Jr., Macon; F. L. Jolley, Atlanta; N. McSwain, Atlanta; D. L. Branyon, Athens; and Mr. Lyndon L. Beall and Mr. Glenn Hogan, Atlanta, ex-officio.

The Committee met on March 11, June 10 and November 18, 1972. The major areas of concern during 1972 were:

- a) An emergency medical plan for Hartsfield Atlanta International Airport
- b) Emergency medical technician/ambulance training and range of capabilities
- c) Emergency medical services plan for the state of Georgia
- d) Ambulance regulations in support of the Ambulance Statute HB370
- e) Legislation *in re*: a medical advisory board to the State Department of Transportation
- f) A technical advisory committee to the Department of Human Resources
- g) The flame-free fabrics provision for infants and children sleepwear

The Committee met with several interested hospital administrators and personnel from the Hartsfield Atlanta International Airport and with others in the Atlanta area in an attempt to devise and contribute to the creation of an emergency plan that would include medical capability for the Hartsfield Atlanta International Airport. At the meeting of the committee conclave, and subsequent Council meetings, further action was deemed necessary by Council. It must be reported that, to date, the committee is unaware of further definitive positive action that has defined an emergency medical plan for the Hartsfield Atlanta International Airport.

It is recommended to Council that an emergency medical plan be established for the Hartsfield Atlanta International Airport, such plan to include appropriate disaster, ambulance and medical components as well as provision of day-to-day care for individuals with acute illness or injury within the airport complex.

The Committee discussed at length the components and personnel involved in training emergency medical technicians/ambulance in Georgia. The course of study in the area technical schools was discussed and approved. The instructors course was also carefully "screened." It became obvious that more and more attention is being directed—and will be required to be directed—toward the administration of intravenous fluids and certain select drugs by carefully selected, highly trained emergency medical technicians at the scene of accident or injury under physicians control and/or with support of telemetry. Legal opinions were requested regarding the relationship of such activity to

the Medical Practices Act. Future activities of the committee will be concerned with developing standards of practice in this area.

A comprehensive Emergency Medical Services plan of the state of Georgia was required for a variety of purposes including unified state agency planning and qualification for certain federal monies in support of Emergency Medical Services of the committee assisted in the preparation of the comprehensive Medical Emergency Services plan. Certain of its members were indicated as creating a part of a medical advisory group to assist in on-going evaluation of that plan. The plan was approved by the Department of Transportation following which funding for Emergency Medical Services was granted the state of Georgia by that agency.

House Bill 370, the Ambulance Statute, having been passed in the 1971-72 legislative session required a set of regulations of the Division of Physical Health of the Department of Human Resources. An ad hoc committee was constituted which established such regulations, but certain changes were made in them administratively after their approval by the ad hoc committee. The draft which was to be submitted for public hearing was therefore discussed in detail at a November 18 combined meeting with the Trauma Committee of the American College of Surgeons. Invited to that meeting were several guests representing providers and other interested agents. A unified position paper was developed which was presented by the Chairman at the time of the hearing. In essence, the committee recommended radio communication in all ambulances and hospitals; training of all drivers of all ambulances; purchase of DOT-approved vehicles whenever state or federal funds were used in ambulance purchase; and the presence of the attendant in the patient compartment at all times during transportation.

On previous occasions a bill to establish a medical advisory board to the State Department of Transportation had failed. Reasons for the failure of this bill were discussed by the committee and, after numerous consultations with concerned individuals and departments and model report language was drafted and presented to council. The report language was adopted by council and referred to the committee on legislation for further action. Subsequently, bills to this end have been introduced to the current legislative session.

As part of the on-going effort in upgrading emergency medical services, it was recognized that a technical advisory committee, somewhat similar to the Governor's Emergency Medical Services Commission, was badly required to support the Board of Human Resources. This group was recommended in the report to the hearing examiner at the time of the ambulance regulation hearing; was included in the comprehensive emergency medical plan for Georgia and was discussed in detail by the committee during 1972. The current status of this committee comprises the following: a 12 member committee has been nominated by the emergency health unit of the Division of Physical Health and has been approved by the Director of that division. The committee roster will require approval by the Commissioner of Human Resources and the Governor, following which appointment will be made officially. Terms of individuals on the committee will be staggered: two, three and one year each. The committee will be comprised of seven physicians and five non-

physicians, and the committee will elect its own chairman. It is unofficially indicated that the chairman of the MAG/EMS committee will be a three year member of the committee.

The Chairman of the Committee participated in a meeting of persons interested in and concerned with flame retardant clothing and materials held in Houston, Texas during 1972. During the year, the passage of a bill by the Congress establishing children's sleepwear from size infant through 6X as being mandatorily flame-free was accomplished. It is probable that these requirements would extend to garments for those unable to escape fire due to illness or injury; and to clothing for older age groups during the next few years. During 1973 a flame-free design conference will be in Baton Rouge, La.; and participation by the MAG committee has been requested and granted.

Plans for on-going effort during 1973 center about the fact that funding for Emergency Medical Services and delivery of same have been severely restricted by the Federal government and by the State. It therefore becomes necessary for the committee to investigate ways and assist communities in methods for optimally delivering emergency care while patient load increases. The concept of regionalized care and the development of an evacuation system for the severely ill and injured promises to occupy much of the committee's attention during 1973.

RECOMMENDATION

With regard to the recommendations for the House, the Committee cites the recommendation relative to the Hartsfield Atlanta International Airport, again as follows:

It is recommended to the House of Delegates that appropriate action be undertaken by the appropriate authorities for the establishment of an emergency medical plan for the Hartsfield Atlanta International Airport, such plan to include appropriate disaster, ambulance and medical components as well as provision of day-to-day care for individuals with acute illness or injury within the airport complex.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee notes the urgency of the recommendation in this report and approves it with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Emergency Medical Services.

**SUPPLEMENTAL REPORT OF
COMMITTEE ON EMERGENCY
MEDICAL SERVICES**

CARL JELENKO, III, M.D.

At the April 21, 1973 meeting of the Committee following a discussion regarding the disastrous effect of P.L. 37 (H.B. 385) on Emergency Medical Services in Georgia, the following Resolution was passed:

“WHEREAS, P.L. 37 signed into law by the Governor on March 15, 1973 effectively cancels the ‘Good Samaritan Law’ of 1969; and

“WHEREAS, the aforementioned law places all emergency care from untrained passerby to physician

under direct supervision and control of the Director of Civil Defense of Georgia; and

“WHEREAS, the law defined ‘emergency’ as ‘a sudden generally unexpected occurrence or set of circumstances demanding immediate action’; and

“WHEREAS, the law requires prior authorization of the Director of Civil Defense before any individual can legally render emergency care or assistance.

“THEREFORE BE IT RESOLVED, that the MAG notify all concerned authorities of the implications of this law; and

“FURTHER BE IT RESOLVED, that the MAG notify its entire membership, in such manner as deemed expedient, of the legal restrictions of this law so that their individual actions may be thoughtfully modified.”

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves the Supplemental Report of the Committee on Emergency Medical Services with the following recommendation: “That the Medical Association of Georgia’s Legislative Committee seek modification of this bill to exclude physicians and certified paramedical personnel from the detrimental effects of this act and to assure this law does not supersede the Good Samaritan Law.”

HOUSE OF DELEGATES ACTION—Adopted the Supplemental Report of the Committee on Emergency Medical Services as amended by the Reference Committee.

Chairman Richardson expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee Report be adopted as a whole. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE B

Charles D. Hollis, M.D., *Chairman*

Chairman Hollis reported to the House of Delegates that the reports and resolutions referred to Reference Committee B had been considered by the Committee which met at 9:00 a.m. in the Teakwood Room, Richmond Motor Hotel, Augusta, Ga. on May 12, 1973. Members of the Committee present included Charles D. Hollis, M.D., Albany, chairman; John P. Tucker, M.D., Moultrie, vice chairman; Edwin C. Evans, M.D., Atlanta; Lewis R. Collins, M.D., Newnan; F. E. Davis, M.D., Waycross and Roy Vandiver, M.D., Decatur.

**RESOLUTION 73-2
PROFESSIONAL STANDARDS
REVIEW ORGANIZATIONS**

W. DANIEL JORDAN, M.D.

DELEGATE FROM MEDICAL ASSOCIATION OF ATLANTA

WHEREAS, the private practice of medicine in the United States has been the cornerstone of the establishment of the highest quality of medical care available to a large population; and

WHEREAS, Professional Standards Review Organizations (as outlined in PL 92-603) would provide for

the establishment of mechanisms for the standardization of medical care and lead to the deterioration of quality of medical care; and

WHEREAS, the Georgia Medical Care Foundation (a subsidiary of the Medical Association of Georgia) has indicated that it will attempt to be designated as a Professional Standards Review Organization; and

WHEREAS, these same Professional Standards Review Organizations would impose restrictive controls upon the private physician in administering his services; now therefore

BE IT RESOLVED that the Medical Association of Georgia duly assembled in Annual Session be recorded as being opposed to the establishment of these same Professional Standards Review Organizations; and

BE IT FURTHER RESOLVED that the delegates to the Medical Association of Georgia instruct the Council of the Medical Association of Georgia to refrain from any activities leading to the formation of these same Professional Standards Review Organizations; and

BE IT FURTHER RESOLVED that the delegates instruct the Council that none of its subsidiary organizations be involved in any such activities.

RESOLUTION 73-3 PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

M. A. GLUCKSMAN, M.D.

DELEGATE FROM THE GLYNN COUNTY MEDICAL
SOCIETY

WHEREAS, Public Law 92-603, establishing Professional Standards Review Organizations, has been enacted by the Congress of the United States; and

WHEREAS, the Members of the Glynn County Medical Society are convinced that said Professional Standards Review Organizations represent another form of governmental encroachment upon the ability of physicians to treat their patients in accordance with their best professional judgment and can result only in a reduction in the quality of care rendered to the sick; and

WHEREAS, the Glynn County Medical Society has resolved to take no active part whatever in the formation of any such Professional Standards Review Organization; NOW THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia and all its agencies will likewise refrain from taking any active part whatever in the formation of any such Professional Standards Review Organization.

RESOLUTION 73-4 PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

JAMES J. OOSTERHOUDT, M.D.

DELEGATE FROM THE WHITFIELD COUNTY
MEDICAL SOCIETY

WHEREAS, Public Law 92-603 mandates the creation of Professional Standards Review Organizations; and

WHEREAS, PSRO's will be required to review all medical services provided under Medicaid and Medicare; and

WHEREAS, until January 1, 1976, PSRO's can be organized only by non-profit professional associations such as the Medical Association of Georgia; and

WHEREAS, if MAG does not act to create a single such organization or multiple PSRO's in Georgia by 1976 some other non-physician organization(s) may be designated; now therefore

BE IT RESOLVED that the Medical Association of Georgia endeavor to handle the PSRO responsibilities in Georgia through a subsidiary organization or organizations; and

BE IT FURTHER RESOLVED that the Medical Association of Georgia notify the Secretary of HEW of its desires to have such organization(s) designated as the PSRO(s) for Georgia.

RESOLUTION 73-5 PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

WARE COUNTY MEDICAL SOCIETY

WHEREAS, the PSRO has been adopted as an integral part of the Medicaid program; and

WHEREAS, the system as presently introduced would cause a deterioration in patient care due to the interference in the judgment of the doctor; and

WHEREAS, this worsening of patient care is against the general aims of the medical profession; now therefore

BE IT RESOLVED that the Ware County Medical Society go on record as being unalterably opposed to the PSRO and that the MAG be asked to express this opinion to all parties involved.

REFERENCE COMMITTEE RECOMMENDATIONS—Reference Committee B heard extensive discussion from informed members of the MAG regarding the new PSRO law. Dr. John Robert Kernodle, chairman, Board of Trustees of AMA, made comments and answered questions regarding AMA's position on the legislation and the initial steps already taken to implement it.

Resolution 73-2, -3, -4 and -5 were considered as a group. Your Committee recommends that all of these resolutions be disapproved and a composite as written by your Committee be substituted as follows:

WHEREAS, there was considerable apprehension expressed among the membership regarding the potential encroachment by government upon the free practice of medicine and the possibility that the present law would prove to be cumbersome, very difficult to implement effectively, discriminatory in certain facets and unreasonably costly; and

WHEREAS, the prevailing opinion seemed to be that the MAG should assume a posture of watchful waiting until certain aspects of the functioning of the law are more clearly explained. The membership seemed to say, however, that it could best protect the interests of the practitioner of medicine and the patient by maintaining communication and involvement with the government agencies working of this program, and

WHEREAS, the MAG accepts the fact that PSRO legislation is now the law of the land, and

WHEREAS, MAG understands and agrees with the



Reference Committee B, charged with covering such controversial subjects as PSRO, hears testimony from Whitfield County delegate James J. Oosterhoudt (above); meets with MAG associate director Adam Jablonowski late into Saturday night to prepare its report for Sunday's House of Delegates session.



principle of accountability for expenditure of public funds, and

WHEREAS, the members of this organization believe that it is highly desirable that any judgment of the quality and appropriateness of a practitioner's delivery of medical care should be made only by a committee of one's peers, and

WHEREAS, the PSRO bill was designed with the purpose of providing a mechanism for offering accountability to government through one's peers, and

WHEREAS, the MAG feels that the principle of accountability should apply also to medical schools and such government installations as military hospitals, VA hospitals, public health hospitals, and state mental health hospitals, and

WHEREAS, the MAG feels that this law is ill-conceived in several of its aspects and very likely will not be implemented in a way to produce the avowed goals of cost containment and improvement of quality of care, and

WHEREAS, the MAG feels that the law as signed will soon cost more than it saves, and

WHEREAS, the MAG at this time realizes that preparations for implementation of the law have not advanced to the point of making any contractual arrangements for Professional Standards Review Organizations;

NOW THEREFORE BE IT RESOLVED, that the MAG House of Delegates work to modify and improve the present PSRO law in a way to make it less restrictive on the practitioner of medicine, less discriminatory to certain providers of services, more economical in its operation and more consistent with delivery of quality medical care, and

BE IT FURTHER RESOLVED, that the House of Delegates instruct its representatives on the Executive Committee and Council to continue to study the procedures being taken to implement the PSRO law, and to offer constructive input in developing guidelines for operation of the program, and

BE IT FURTHER RESOLVED, that the MAG House of Delegates direct its Executive Committee

and Council or any of its subsidiary organizations to enter no formal contract with any government agency without referring the matter back to the House of Delegates for consideration, and

BE IT FURTHER RESOLVED, that the MAG Headquarters be required to make regular reports to the county society officers regarding developments in the PSRO Program, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the presidents of the 50 state medical societies, and

BE IT FURTHER RESOLVED, that the delegation from MAG to AMA shall present this resolution to the AMA House of Delegates next month as an item of information.

HOUSE OF DELEGATES ACTION—Delegate L. C. Buchanan of DeKalb County moved in his own behalf and behalf of his county society that the substitute resolution proposed by the Reference Committee be amended in the second resolve by adding a phrase at the end of that resolve to provide no additional federal funds are sought for these purposes. By voice vote and subsequently by standing vote this proposed amendment was defeated.

Delegate L. C. Buchanan speaking in behalf of the DeKalb County Society moved that this resolution be amended by the addition of the following phraseology at the end of the end of the last resolve, "—and MAG Delegates be instructed to vote against implementation of the PSRO without approval of the MAG House of Delegates." On a voice vote this amendment was defeated. The House of Delegates then voted to adopt the report of the Reference Committee.

PRESIDENT-ELECT'S SPEECH

C. E. BOHLER, M.D.

Members of the Medical Association of Georgia and Honored Guests:

This is a great honor you have given me and I am grateful. You will find that I am a very poor speaker.

I envy Bill Dowda and Billy Mitchell their ability to transmit their thoughts through speech. I hope that I will be able to fulfill my duties during the following 12 months in a manner acceptable to you, the membership of the Medical Association of Georgia.

When someone asked me what I intended to say at this time, I replied—not very much—for I have attended 12 previous consecutive Annual Sessions and I have heard all the speeches by all the gifted and dedicated previous presidents of this Association and the only statement I remember was Kirk Train's when he handed the gavel to Tex Eldridge along with a length of rope and said "the rope is to hang yourself with." Now I don't plan to hang myself and I sincerely hope that you all will not want to hang me during the following 12 months but I realize, and I know you realize, the enormity of the job that will be mine; but with the excellent assistance and expertise of very good friends of the Executive Committee, the previous Presidents, Bill Dowda and Billy Mitchell, Council and with the help of my friends who are active and concerned members of MAG all over the state, we will get the job done; and I hope in an acceptable manner.

I am exceedingly pleased that this 119th Annual Session is taking place in the city of Augusta. I, along with many of you, spent four years in this city while attending the Medical College of Georgia. It was my good fortune to have osteology and gross anatomy under our beloved Dr. G. Lombard Kelly and who could forget his lectures during the Junior year on that greatest and most intriguing of all mysteries—SEX?

Dr. Harry O'Rear was unexcelled as a teacher of Pediatrics and he subsequently became dean and the third president of the Medical School. The Medical College has had some of its greatest years under his leadership.

As you know, Dr. Edgar Pund was our second president and who could ever forget Dr. Pund's lectures and slide presentations during the sophomore year in pathology—especially Dan Bateman? I feel the Medical College has been in excellent hands in the past and will continue to grow under the capable direction of its new president, Dr. William H. Moretz.

I would like to take this opportunity to offer the Medical College of Georgia and the Emory University School of Medicine the support and cooperation of MAG during the ensuing years.

I will take only a few minutes to acquaint you with some of the problems we, of the Medical Association of Georgia, will face in the following year.

We have Medicare and we have Medicaid. The Federal Government is spending billions of dollars for health care delivery. From past experience we all know that when Federal money is spent, Federal money must be accounted for. Since the beginning of the Medicare-Medicaid program, accountability on the part of institutions and physicians in the business of delivering health care in some areas of this country has been lax and perhaps in some instances, haphazard.

As all of you know, the Bennett Amendment, the Professional Standards Review Organization, or PSRO Legislation, became law in October 1972. Now I don't like this law, MAG doesn't like this law, and the AMA doesn't like this law. And I am sure hundreds of physicians who are not members of any medical organiza-

tion do not like this law either. But it is a law and it will be implemented.

I will not go into detail concerning this legislation but will briefly outline the problems that will face us, the MAG, during the next few months.

The purpose of the law is as follows and I read from the Act: "In order to promote the effective, efficient and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this program to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional standards for the provision of health care and that payment for these services will be made only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for the period these services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion."

This, my friends, means that the Federal Government has forced peer review and/or utilization review upon us. This law will be implemented. PSRO areas throughout the nation will be designated by the Secretary of HEW prior to January 1, 1974.

Doctors of medicine or osteopathy engaged in the practice of medicine and surgery within the designated areas will be given the first opportunity to organize PSRO organizations. All physicians in these PSRO's will be encouraged to take part in the review activities of the organization. Participating physicians in the designated area will not be required to belong to any dues-paying organization such as MAG or the Georgia Medical Care Foundation.

Initially, PSRO activity will be directed at and concerned with institutional care, that is, hospitals and nursing homes; however, eventually it must concern itself with all medical care rendered under the Social Security Act, irrespective of where that care is rendered.

There has been talk of non-compliance. Some say we should not cooperate. I would remind you that organized medicine did not cooperate or assist in the preparation of Title II, the Medicare-Medicaid Law—and in the end we have had to submit to regulations and fee-setting not to our liking.

In Macon last month, during our PSRO Conference, a professed friend of medicine, Mr. Douglas Richard, regional representative, Bureau of Health Insurance for the Social Security Administration, informed us in no uncertain terms, that this is Medicine's last opportunity to police our own affairs and, if we fail, we will most certainly be subjected to regulations and review by other organizations not to our liking.

PSRO will be aired in a Reference Committee during this Annual Session. I urge you all to get a copy of the law and read it. You must urge your associates back home to read it; it is the law of the land.

The Executive Committee and Council do not know how or when Georgia will be designated. The Medical Association of Georgia has asked the Secretary of HEW to declare Georgia a single PSRO area. We have also requested of him that a subsidiary organization of the MAG be considered at the appropriate time as the PSRO designee. Our attorney has begun the necessary paper work for formation of this organization.

The Medical Association of Atlanta, through its foundation, has asked that its area be designated a PSRO; should the Secretary of HEW wish to divide the state into two or more areas.

I apologize for spending so much time on this subject but as I stated at the beginning, this is probably the most significant legislation ever passed concerning your future, my future and future of Medicine as a whole.

I firmly believe that there will be some form of National Health Insurance within the next five years. We must, within the short time left us, unite together and with honesty, cooperation and intelligence do what we must to assure the American people and our lawmakers that for each dollar they spend for health services, they will receive full measure in return. If we do this, the National Health Insurance game will be played in our ball park and according to our rules. If we fail, you and I know who will write the rules of the game and they won't be to our liking.

I urge you, please think carefully, listen carefully, and study the law. As your President, I am your servant. The Executive Committee and Council and I will do as you direct. There are truly times that try physicians' souls and we have more trying times before us. I will keep foremost in my mind at all times the welfare of the practicing physicians of Georgia and the members of the Medical Association of Georgia.

I urge your cooperation, and I solicit your advice and counsel.

Thank you!

REFERENCE COMMITTEE RECOMMENDATION
—Your committee recommends acceptance with appreciation of our President-Elect's Speech and recommends it be filed for information.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect as recommended by the Reference Committee.

REPORT OF THE COMMITTEE ON PEER REVIEW

JOHN R. MCCAIN, M.D.

The Peer Review Committee proposes that it continue its responsibility in functioning as the final level of the peer review appeals mechanism. (It is understood that appeal is available from the Peer Review Committee to the MAG Executive Committee of Council, but that such an appeal covers only an evaluation of the procedure followed and not of the substance of the review.)

The Peer Review Committee makes two recommendations and one request to the House of Delegates:

Recommendation regarding the development of policy for the review of medical services:

It is highly desirable that the review of medical services be based upon policies which have been accurately

ly determined to represent the best in current medical knowledge. Such policies are involved in establishing the appropriate frequency of visits to, or by, a physician. They also involve the type and frequency of the treatment provided.

Such policy decisions become more difficult as they relate to specific drugs and plans of therapy for specific disease entities.

The decisions become even more difficult as evaluations are made regarding new proposals for the diagnosis and treatment of diseases.

Identification must be made of the problems and difficulties in the review of medical services for which policies should be developed. Specific problems may be identified by any organization involved in the peer review of medical services, such as the Peer Review Committee, Foundations for Medical Care, or a PSRO.

It is desirable that the best available authorities be involved in the development of policy for the review of medical services. Policy should not be developed on a casual basis, but by careful study by the representatives of the medical specialties involved, with the use of specialty consultants as may be indicated.

It is important that policy for the review of the specific medical services be consistent. Accordingly, it is desirable that the development of policy for the review of medical services in Georgia be the responsibility of a specific committee.

The MAG has assigned to the Peer Review Committee the responsibility for the development of policy for the review of medical services. The Peer Review Committee consists of the representatives of the medical specialty groups designated by the MAG. Each specialty organization representative has immediately available to him appropriate authorities and consultants in his specialty as may be required.

RECOMMENDATIONS

1. The Medical Association of Georgia request that all organizations in Georgia, involved in Peer Review, refer all problems involving the development of policy for the review of medical services to the MAG Committee on Peer Review.

2. The Peer Review Committee is to utilize appropriate specialists to develop such policy recommendations as may be found to be advantageous.

3. The policy recommendation of the Peer Review Committee shall be submitted to the Executive Committee of MAG Council for its consideration and action.

Recommendation Regarding the Educational Aspects of Peer Review:

The educational aspects of Peer Review constitute perhaps the most significant contribution which can be made by the review process.

The education of the physicians (as well as others involved in the provision of health services) should include information regarding the quality of the medical care which is expected of them. It is unwise to criticize the activities of an individual unless he or she has first been advised regarding what is expected of him or of her.

The peer review of medical services should identify specific areas in which additional educational services should be provided. The "area" could be related to a

specific disease category, it could relate to a specific geographic area of the state.

It is desirable that the educational aspects of peer review be coordinated through a specific committee, or committees, of MAG.

RECOMMENDATION

1. The Peer Review Committee be requested to cooperate with the organizations involved in peer review in Georgia to identify the specific aspects of peer review in which educational activities are desirable.

2. The Peer Review Committee be requested to develop specific educational programs for the aspects of peer review which have been identified as educational needs.

3. The Peer Review Committee submit proposed programs to the Executive Committee of MAG Council for its consideration.

4. The Executive Committee request the Peer Review Committee and/or such other committee(s) as may be desirable to proceed with such proposed educational programs as it may approve.

RECOMMENDATION

The Peer Review Committee *requests* that the House of Delegates, through the Committee on Education and through the Professional Conduct and Medical Ethics Committee, as previously indicated by the MAG Council, proceed with the Composite Board of Medical Examiners to develop a Medical Disciplinary Board.

The attention of the House of Delegates and of these two Committees is directed to the fact that the AMA staff has a very considerable amount of information available regarding the development of a Medical Disciplinary Board. The Peer Review Committee has already obtained some of the AMA information for use by the MAG Committees. It is prepared to obtain additional information if it is desired.

The Peer Review Committee is prepared to assist in any way possible in the development of a satisfactory Medical Disciplinary Board.

The Peer Review Committee requests that it be advised regarding the current status and of the progress being made toward the development of the Medical Disciplinary Board.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with the following changes. On page two, delete lines 21 through 31 and substitute: "Since the Peer Review Committee is already the final appeal authority in Peer Review questions for the Medical Association of Georgia, it is recommended that the Peer Review Committee utilize appropriate specialists to develop such policy recommendations as may be found to be advantageous and that these recommendations be submitted to the Executive Committee of Council for consideration and action as it deems appropriate."

On page three, delete lines nine through 22 and substitute, "The House instructs the Peer Review Committee to identify educational needs of physicians in the state and the Education Committee to implement programs designed to alleviate these needs, and present to the Executive Committee such programs for its approval."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Peer Review.

EXPERIMENTAL MEDICAL CARE REVIEW ORGANIZATION

F. WILLIAM DOWDA, M.D., *Principal Investigator*

The Experimental Medical Care Review Organization (EMCRO) continues the development of its two data services: 1) A hospital discharge abstract system, and 2) A system of centralized utilization review for nursing homes.

HOSPITALS

The hospital discharge abstract system will assist Medical Audit/Utilization Review Committees of hospitals in performing their review. This will be accomplished by the application of screening parameters to the abstracts of all medical records of patients discharged from participating hospitals. Abstracts not falling within these computer-applied screens will be identified through exception reports to the appropriate committee of the hospital medical staff. The system, then, may serve as an integral component of a hospital's Quality Assurance Program (QAP)—by identifying trends through retrospective review—or of a Continuing Education Program—by identifying needs for continuing education as well as a means of measuring the effectiveness of Continuing Education Programs.

Screens for a total of 74 diagnoses and major surgical procedures have been developed to date by the following state specialty societies: Obstetrics-Gynecology, General Surgery, Orthopedics, Internal Medicine, Pediatrics, Urology, Ophthalmology, Otolaryngology, Dermatology, and Neurosurgery. Additional meetings with these and other specialty societies are planned. These meetings are staffed by EMCRO personnel at the time and place designated by the chairman of the specialty panel. Representatives of other specialties often attend as consultants. It is expected that in the future, multi-disciplinary efforts will be increased, especially in the area of cancer treatment.

In addition to the above emphasis on quality of care, the data service is also expected to meet the needs of medical records departments and hospital administrators for information. The system will provide to the medical records department indexes required by the Joint Commission on Accreditation of Hospitals. The costly manual preparation of these indexes will thus no longer be required. Management indicators of value to the hospital administrator will also be tabulated in an effort to improve the efficiency and effectiveness of hospital management. Volumetric measures of the utilization of intensive care units and special procedures rooms, etc. will be made. The hospital service area and major sources of payment, etc. will also be identified. Initial field testing of program components will begin during the summer of 1973. The coding manual and abstract form, as well as some of the computer programs will likely require modification during the field test period. Further, it is expected that the specialty panels will wish to review their screens based on the experience of the field test. A line-item analysis of the screens will be prepared by the EMCRO staff for the specialty panels' consideration.

The Interspecialty Council has coordinated the meet-

ings of the various panels. It is expected that the Interspecialty Council will continue their support and will develop multi-disciplinary components of the system. The EMCRO will also work with MAG's Cancer Committee in an attempt to incorporate the basic requirements of a Tumor Registry into our data service.

NURSING HOMES

The EMCRO's Centralized Utilization Review System for nursing homes is an attempt to evaluate appropriateness of level of care and to appraise quality of care in nursing homes. The System is expected to satisfy the requirements of the Medicaid Program for review of all patients in skilled homes. This system is being developed in close cooperation with GNHA.

An outline of the system's operation is not yet complete. However, some of the coding techniques are now in the process of initial field-testing. A more advanced stage of field-testing will begin July 1, 1973, in a number of GNHA homes. MAG's Committee on Geriatric Medicine is in the process of developing screens for computer review of the abstracts prepared within this program. Twelve diagnoses are currently under consideration. These were selected on the basis of frequency of occurrence in nursing homes. These screens, too, are expected to be modified over time as additional data is collected.

This data service will prepare claims as well as provide management data to the nursing home administrators. A patient placement service will also be developed to assist physicians in locating available beds by geographical area.

RECOMMENDATION

It is recommended that the House of Delegates delegate to the Council of MAG the responsibility for reviewing these experimental activities before they become operational. This is necessary in that EMCRO's data services may be ready for operation before May of 1974, but are not yet sufficiently developed to be reviewed.

REFERENCE COMMITTEE RECOMMENDATION

—It was noted by your committee that last year the House of Delegates asked this organization to make a report to the House before any of its activities become operational. There is a request this year from the EMCRO for this House to delegate to Council the responsibility for reviewing its experimental activities before they are put into effect.

Your reference committee recommends that the report be approved with the following changes: On page 1, line 14, the words "Quality Assurance Program (QAP)" be deleted and replaced by "program of quality assurance."

We further recommend disapproval of the recommendation on page two in the belief that the action of this House taken last year should remain in effect. All final studies and conclusions of the EMCRO shall be submitted to the House of Delegates before any action is taken to make its programs operational. We also recommend that should Council conclude that timing is critical in making a decision about utilizing the methods as developed by EMCRO, a special session of the House of Delegates be called for the purpose.

HOUSE OF DELEGATES ACTION—Delegate Charles W. McDowell, Jr., DeKalb County moved that the report of the Reference Committee be amended to provide that no further federal funds be sought (by EMCRO) or applied for until approved by the MAG House of Delegates. On a voice vote this proposed amendment was defeated.

A subsequent amendment was proposed by Delegate Jack Raines of Muscogee County Medical Society by adding a new sentence at the end of the Reference Committee report as follows: "It is further recommended that EMCRO forward to each county medical society a detailed accounting of financial expenditures." Delegate M. A. Glucksman of Glenn County Medical Society moved to amend the Raines Amendment by providing that EMCRO would also send to each county medical society a copy of the EMCRO grant continuation request. The amendment was accepted by Dr. Raines and following a second, the House voted to approve the amendment by adding an additional sentence on line 24 of the Reference Committee Report the following: "It is further recommended that EMCRO forward to each county medical society a detailed accounting of financial expenditures and a copy of the EMCRO grant continuation request."

The House of Delegates then voted its approval of the report of the Reference Committee as amended.

GEORGIA MEDICAL CARE FOUNDATION

F. W. DOWDA, M.D.

The Georgia Medical Care Foundation is the primary source of peer review functions in the State of Georgia. Incorporated in October of 1970, under the sponsorship of the Medical Association of Georgia it has developed, during its short existence, into one of the most effective organizations of its kind anywhere in the country.

Most of the activities of the Foundation have been centered around a contract with the Georgia Department of Human Resources to provide the review mechanism and procedures and medical expertise in the State's administration of the Title 19 Medicaid Program.

Each year over \$150 million are spent by Georgia taxpayers in order to provide a comprehensive medical program to thousands of medically indigent citizens. It is the Foundation's responsibility to assure the State of Georgia and its citizens that these funds are properly allocated—that medical services are appropriate; and that quality is present and ever improving.

The Foundation reviews claims of physicians, hospitals and nursing homes. During the fiscal year beginning July 1, 1972, it has reviewed approximately 10 per cent of the total volume of such claims. As of March 31 the Foundation staff, its physician consultants, its specialty panel members, and the Board of Directors have reviewed 89,000 physician claims, 11,000 hospital admissions, and 11,000 nursing home admissions.

As the result of these reviews the Medical Association of Georgia through its Foundation has been able to demonstrate its own ability, without governmental or outside interference, to properly address itself to the needs of the public by helping to improve the present

high quality of medical services; and at the same time helped control the upwards cost spiral of all medical care in Georgia.

In addition to its contracts with the State, the Foundation has similar functions with CHAMPUS, Commercial Insurance Carriers, and to a lesser degree with Medicare.

Less publicized, but just as important, is the Foundation's proven ability to act as the spokesman for the medical profession to help improve the medical insurance coverage available to the average citizen of Georgia; and to present a unified and strong voice in securing redress of unsatisfactory action taken by insurance carriers and fiscal intermediaries.

Since its last annual report the Foundation has:

1. Saved the State of Georgia and its taxpayers millions of dollars through nursing home, hospital and physician education—without affecting quality of care.

2. Proposed and expects to receive from the State of Georgia a contract which will provide in-depth on-site review by a physician consultant-headed team of all nursing homes in Georgia and expects to further improve the savings of taxpayers dollars. At the same time this program will assist the nursing homes to fulfill their role and the requirements of the law under both Medicaid and Medicare.

3. Instituted a Concurrent Hospitalization Review Program in a number of hospitals which has demonstrated a significant reduction of average length of stay per patient, again without reduction in quality. The dollar savings has also been significant. It is anticipated this program will be substantially expanded during the coming year.

4. Executed a contract with United Physicians Service, Inc. of Atlanta (Blue Shield) to provide complete peer review to all subscribers thereby eliminating almost completely the possibility of arbitrary unilateral decisions.

It is expected that a hospitalization review program will be placed in effect under the control of the Foundation with Atlanta Blue Cross in the near future.

5. Begun negotiations with a number of other large insurance carriers to provide similar services.

6. Begun a meaningful dialogue with the national and local Health Insurance Council (HIC), which represents most of the health insurers in Georgia, in order to create a model working document of the responsibilities of carriers to the medical profession and the insured public.

Through the various medical specialty groups it is hoped that insurance carriers will provide benefits for services so often needed but presently lacking in most coverages.

At the same time the Foundation hopes to take over the role of adequate supervision of medical services addressing itself to appropriateness of service, reasonable cost, and provider education and serving as the appellate mechanism for providers of medical service.

The past year of Foundation operation has been very effective. During the coming year the Foundation will complete its developmental stage and enter into an era of service to Medical Association of Georgia members never achieved before in Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your committee recommends approval of this report with the addition of a recommendation at the

end of the report. Information presented to your reference committee indicated that the Board of Directors of the Foundation is involved too extensively in the procedures of claims' review. It would seem desirable for the Board to have more time to devote to the consideration of policy and long range planning for the Foundation. Therefore, your committee recommends (1) that the Board of Directors of the Foundation establish a separate committee to aid in the performance of claims' review and (2) that the Board of Directors of the Foundation utilize the members of the MAG Peer Review Committee and specialty societies primarily for utilization and quality review.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Care Foundation as amended by the Reference Committee.

CHAIRMAN OF COUNCIL

DAVID A. WELLS, M.D.

I have enjoyed the honor and privilege of serving as Chairman of the Council of MAG during the past year. I have attended all of the Council meetings and all of the Executive Committee meetings that were held in the state. I feel that the MAG staff members have done an excellent job during the year and should be commended for their efforts.

Organized medicine faces an increasing task in the coming years. The explosive increase of governmental influence in health matters make mandatory a strong, effective, representative association. I feel that our present structure (House of Delegates, Council, Executive Committee, District Societies, local societies) has been effective in the past. For the future I believe that we need to look carefully at this structure.

Many county societies have too few members to function. The district societies elect representatives to Council (almost their only function). The boundaries of the districts no longer follow the congressional district lines. The Executive Committee meets monthly, and because of this must act on many urgent and needed matters. In my opinion, Council has grown too large. Much of the business at Council meetings could have been handled by staff or Executive Committee. The House of Delegates meets only once a year (amid the social confusion of specialty meetings, parties, reunions, etc.). It is difficult for the delegates to be really informed of the problems facing the Association.

The above is just a brief summary of our present organizational structure.

RECOMMENDATIONS

1. Encourage small county societies to merge to increase number of members for more effectiveness.

2. Divide the state into districts that have geographical and "trade area" cohesiveness. The old congressional district lines may fill this need. Present congressional districts change each 10 years. We should divorce ourselves from this need to change.

3. Consider ways to make Council smaller, or to be sure that it does not grow larger.

4. Have Council meetings more of a forum to discuss problems of the Association, rather than handling routine matters that could be settled by the Executive Committee.

5. The Executive Committee is composed of eight members elected by the entire association and only two other members. I feel that this composition gives adequate representation. The Executive Committee should have more authority to act on its own responsibility.

6. The House of Delegates is the ultimate authority of the Association. Its yearly meeting should be separated from the other parts of our annual meeting, as it is now held. The scientific meeting portion could be held on a different date.

7. House of Delegates instruct Executive Committee of Council to appoint an ad hoc committee to study the above suggestions (1 through 6) and make recommendations for implementation, if appropriate, to the Executive Committee. In addition, such recommendations, if any, should be referred to Council for its approval. Further, the ad hoc committee appointed by the Executive Committee should be composed of a majority of physicians not members of Council, thus enhancing the prospects for fresh points of view.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bartow				
Virginia Hamilton				
Cartersville	11	6	11	6
Carroll-Douglas-Haralson				
Mary J. Touchton				
Carrollton	40	37	39	36
Floyd				
John R. Lovvorn				
Rome	93	70	94	68
Gordon				
Frank M. Alvarez				
Calhoun	9	8	10	9
Walker-Catoosa-Dade				
M. K. Cureton				
LaFayette	37	21	36	19
Whitfield				
Paul L. Bradley				
Dalton	51	41	54	45
	242	184	244	183

REFERENCE COMMITTEE RECOMMENDATION
 —Your committee recommends approval of this report with these changes. Recommendation six on page two is deleted in its entirety. This action was taken with the approval of the author of the report and the understanding that the question of changing the format of Annual Session was discussed and will be reported on by Reference Committee A.

Under Recommendation Seven, the following changes are recommended: Rewrite from line 55 as follows, "6. The House of Delegates instructs the Executive Committee of Council to appoint an Ad Hoc Committee on Organization and Functions to study the above suggestions (1 through 5), any other items as may be related to the structure, organization or functions of MAG and make recommendations for implementation to the Executive Committee and Council, if appropriate. In addition, such recommendations should be reported to the next Session of this House of Delegates. At that time this House should

consider creating a standing committee on organization and functions.

Further, the Ad Hoc Committee appointed by the Executive Committee should be composed of seven physician members of MAG, three of whom are selected from Council and four others from the general membership, thus enhancing the prospects for fresh points of view."

HOUSE OF DELEGATES ACTION—Adopted the Report of the Chairman of Council as amended by the Reference Committee.

Chairman Hollis then expressed his appreciation to the members of the Reference Committee for their time and effort and expressed a special thanks to Dr. John R. Kernodle, chairman of the AMA Board of Trustees for the time that he gave and moved that the Reference Committee Report be adopted as a whole as amended. This motion was duly seconded and approved. Dr. Hollis and Reference Committee B were accorded a standing ovation for this report.

REPORT OF REFERENCE COMMITTEE C

W. Daniel Jordan, M.D., *Chairman*

Chairman Jordan reported to the House of Delegates that the reports and resolutions referred to Reference Committee C had been considered by the Committee which met at 9:00 a.m., on May 12, 1973 in the Boxwood Room, Richmond Hotel, Augusta, Ga. Members of the Committee present included: W. Daniel Jordan, M.D., Atlanta, chairman; F. Norman Bowles, M.D., Austell; L. Roy Williams, M.D., Wadley; Warren Baxley, M.D., Blakely; Dewey Barton, M.D., Valdosta.

RESOLUTION 73-6
 NEWBORN INSURANCE COVERAGE

JOSEPH M. ALMAND, M.D., *LaGrange*

WHEREAS, the Georgia Chapter of the American Academy of Pediatrics is vitally concerned with all Georgia Insurance Companies with dependent coverage having newborn coverage from birth.

WHEREAS, the Medical Association of Georgia acknowledges the need for all persons to have the opportunity to purchase such coverage; and

WHEREAS, the MAG believes a publication and contact campaign can accomplish a satisfactory result to the problem, without the possibility of creating additional problems arising from legislation; and,

WHEREAS, the MAG and the GCAAP join forces to better resolve the problem without going to the Georgia General Assembly; therefore be it

RESOLVED, that the MAG activate a campaign to educate the public, inform the major businesses, and contact labor unions in Georgia informing them of this need; and be it further,

RESOLVED, that all county medical societies will be requested to help inform their local physicians and local business leaders of this need.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the approval of this resolution with the amendment of the first resolved portion. When amended, this portion would read: "Resolved, that MAG activate a campaign to educate the public by informing the major businesses, contacting labor organizations, and other suitable means necessary of informing Georgia citizens of the need for all Georgia insurance companies with dependent coverage having newborn coverage from birth.

HOUSE OF DELEGATES ACTION—Adopted Resolution 73-6 as amended by the Reference Committee.

RESOLUTION 73-1 OSTEOPATHIC MEMBERSHIP IN MAG

WILLIAM RAWLS, M.D.
FOR DEKALB COUNTY MEDICAL SOCIETY

WHEREAS, active channels of communication have been established between the membership of the Medical Association of Georgia and the membership of the Georgia Osteopathic Medical Association through county and state liaison committees; and,

WHEREAS, these committees have been effective in promoting improved relations as well as promulgating useful information between the two bodies; and,

WHEREAS, membership in the AOA precludes membership in any association of doctors of medicine; and,

WHEREAS, the members of the GOMA have expressed no desire to gain membership in the MAG; therefore be it

RESOLVED, that the MAG continue its efforts at improved communication through its liaison committees; and be it further,

RESOLVED, that the MAG defer until a more appropriate time any action pertaining to membership for Doctors of Osteopathy in the MAG.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this resolution.

HOUSE OF DELEGATES ACTION—Adopted this Resolution 73-1 as presented.

COMMITTEE ON QUACKERY

JAMES A. KAUFMANN, M.D.

The Committee on Quackery continued the never-ending battle of informing the public and the members of the Georgia General Assembly of the dangers of the chiropractic cult and others.

With last year's reorganization battle over, there was more time to devote our efforts in defeating any and all chiropractic legislation introduced this year.

The Chiropractic lobby in Georgia has grown stronger and stronger the past several years. Through the united efforts of 350 chiropractors licensed in Georgia, their goal of equal recognition as physicians could possibly be within reach unless all physicians unite to defeat the chiropractic quacks in Georgia.

In the 1973 Georgia General Assembly two chiropractic bills were introduced. House bill 147, "Freedom of Choice" Legislation would require all Health and Accident Insurance policies to reimburse chiroprac-

tors for their services. If enacted, neither the insurance company nor the insured would have "Freedom of Choice" whether or not they wished to sell or purchase chiropractic coverage. Bills such as this would take away an individual's right of contract and "force" you to buy the services of chiropractors knowing you will never utilize the services of these quacks. In effect, such a law would force the insurance industry to raise premiums on all health and accident insurance policies offered. All Georgia citizens should have the freedom of choice of the type of coverage they wish to purchase.

Another effect of H.B. 147 would be equal treatment of chiropractors and physicians under all insurance policies. Every knowledgeable person should know quacks such as chiropractors are not physicians in any comparison.

Fortunately, through the many efforts of MAG members in contacting their legislators, H.B. 147 was voted down in the House Insurance Committee. However, we can expect to see this identical bill again next year as we did this year, and in 1972. If we expect to continue defeating this type of legislation all physicians must continue to contact their legislators and inform them of the dangerous hazards of chiropractors and the effects of such legislation.

A second chiropractic sponsored bill was introduced this year. House Bill 858 would expand Medicaid payments to "Physician's services, including chiropractic services, whether furnished in the office, the patient's home, the hospital, a skilled nursing home, or elsewhere." H.B. 858 in no way could reduce Medicaid payments. This is the chiropractic quacks "new pet" legislation. They realize the amount of money they could gain by legislation of this type, compensating them for their back-popping services in the home, hospital, nursing home, office, or *elsewhere*. This bill was referred to a 12 month study committee in the House Human Relations Committee. Once again, through the many efforts of the physicians around Georgia we were able to keep this bill from becoming enacted.

I strongly urge every MAG member, as well as every physician in Georgia and the country to mount an all out campaign in helping defeat any type legislation previously mentioned that will upgrade the status of quacks such as chiropractors.

MAG took the offensive this year and introduced House Bill 699, Professional Healing Arts licensure. This bill would require anyone who applies for a Georgia license to practice either dentistry, medicine, optometry, osteopathy, podiatry, or chiropractic be a graduate of an accredited school recognized by the National Commission on Accrediting or the U.S. Department of Health, Education, and Welfare. There is a grandfather clause thus not affecting anyone presently licensed or practicing in Georgia.

Chiropractic schools are the only schools not recognized by either the National Commission on Accrediting or the U.S. Department of HEW. This further exonerates the fact that these proposed individuals dealing in the healing arts are quacks and have no right to claim cures and administer any health care to the citizens of Georgia.

H.B. 699 received a favorable recommendation from the House Health and Ecology Committee. It was sent to the House Rules Committee where Dr. Rogers, Jim

Moffett, Rusty Kidd, myself, and numerous representatives decided not to put it on the calendar in 1973, but wait until 1974 and give this bill an extremely strong push for passage. In order for this bill to pass next year, this strong push must come from every MAG member contacting his individual Representatives and Senators informing them of such legislation and requesting their support for its passage.

Chiropractic remains the over-riding quackery problem in Georgia. Effectively controlling chiropractic is the number one objective of our Committee on Quackery.

RECOMMENDATION

Your Committee recommends that the Committee on Quackery be continued and that it continue to lead the entire medical profession in efforts to combat the spread of chiropractic; and that all available support be given to any legislation that will curb the activities of chiropractors in Georgia.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee recommends approval of the recommendation of the Committee on Quackery with commendation to this committee for its activities, especially in the halls of the state legislature.

HOUSE OF DELEGATES ACTION—Delegate James A. Kaufmann moved that the report of the Committee on Quackery be amended by inserting immediately after line 16 on page 3 of the report the following: "The Quackery Committee is also concerned about the very real dangers of hypnosis when practiced by unqualified and improperly trained persons. This is occurring on a widespread basis in Georgia today. The Quackery Committee will work toward badly needed corrective legislation in this field. In addition, we will attempt to increase public education about this danger."

A second was made to this motion and duly adopted by the House.

The House then adopted the report of the Committee on Quackery as amended.

INSURANCE AND ECONOMICS COMMITTEE

WILLIAM W. MOORE, JR., M.D.

The Insurance and Economics Committee held its annual meeting with the representatives of the St. Paul Fire and Marine Insurance Company on 19 April 1973, and the Committee agreed to a 13.7 per cent composite increase in premiums for professional liability insurance for the year 1973-74, effective 1 June 1973. The attached chart is a breakdown, by class, showing current rate, new rate, and per cent of increase.

The Top Brass, or million dollar umbrella, rate will increase the same per cent, by class.

To emphasize a point, please don't say "This can't happen to me," as St. Paul has already received 52 claims this year.

REFERENCE COMMITTEE RECOMMENDATION

—It is noted that there were no recommendations contained in the Insurance and Economics Committee, but that it was referred to this Reference Committee at the request of a delegate. In the discussion before the Reference Committee this delegate stated that he fully approved of the report of the Insurance

PROFESSIONAL LIABILITY—100/300,000 Limit Rates

Classification of Insured	Current	New	Per Cent of Increase
I. Dermatologists, psychiatrists, pathologists, radiologists and pediatricians (psychiatrists and radiologists using therapy should double rates) ..	\$212	\$227	7.1
II. Physicians, minor surgery ..	341	398	16.7
III. Surgeons, ophthalmologists and proctologists	798	862	8.0
IV. Surgeons, general, thoracic, cardiac, urologists, otolaryngologists (no plastic), vascular	934	1,077	15.3
V. Surgeons, anesthesiologists, orthopedists, neurosurgeons, otolaryngologists (plastic), obstetricians, gynecologists, plastic surgeons	1,047	1,221	16.6

and Economics Committee and that his request for referral concerned only procedural mechanisms when an individual physician was threatened with a malpractice suit. Answers were provided to this delegate by a member of the Insurance and Economics Committee. Your reference committee recommends approval of the Report of the Insurance and Economics Committee with commendation and further urges all MAG members to contact members of Insurance and Economics Committee for advice as well as to contact their malpractice carrier in the event of a threat of a malpractice suit.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Insurance and Economics.

COMMITTEE ON CONSTITUTION AND BYLAWS

JOHN T. MAULDIN, M.D.

ITEM 1: PAST PRESIDENTS AS HONORARY MEMBERS OF COUNCIL AND AMA ALTERNATE DELEGATES AS EX-OFFICIO MEMBERS OF COUNCIL

On December 11, 1971 the Council took the following action: "Dr. Bohler read a resolution to allow Past Presidents of MAG to be made Honorary Councilors and invited to attend all Council meetings, and to ask the Constitution and Bylaws Committee to make the necessary enabling changes. On motion duly made and seconded, this resolution was approved."

On February 11, 1972 the Council took the following action: "Council heard the recommendation that the Constitution and Bylaws Committee prepare language to make the Alternate Delegates to the American Medical Association Ex-Officio members of Council without the right to vote. This motion (Dowda-El-dridge) was adopted."

This may be accomplished in the Constitution by inserting between the words "Delegates to" the words "and Alternate Delegates" in the second sentence to Article VI, Section 1, Composition. Also in the same sentence by inserting between the words "Journal and"

the words "Past Presidents" so that the sentence would read as follows:

"Delegates and Alternate Delegates to the AMA, the Treasurer, Editor of the *Journal*, Past Presidents, and the Executive Director shall be Ex-Officio members of Council without the right to vote."

The following changes would be required in the Bylaws in order to accomplish these recommendations:

"Chapter 4, Section 1, Composition:" The first sentence is changed by inserting the following between the words "House of Delegates and Councilors," the words "Past Presidents," so that the sentence would read as follows: "The Council is composed of the President and President-Elect, Immediate Past President, who shall serve as a full member of Council for a period of three years, two Vice Presidents, Secretary, Speaker of the House of Delegates or Vice Speaker of the House of Delegates, Past Presidents and Councilors or Vice Councilors selected as follows:"

The last Paragraph of Chapter 4, Section 1, Composition is changed as follows: The last sentence of the last paragraph would be changed by inserting between the words "Delegates to" the words "and Alternate Delegates"; and also adding between the words "*Journal*, and" the words "Past Presidents,". So that the last sentence of Section 1 would read as follows: "Delegates and Alternate Delegates to the American Medical Association, the Editor of the *Journal*, Past Presidents, and the Executive Director shall be Ex-Officio members of the Council without the right to vote."

The above recommendations were approved by the 1972 House of Delegates as a constitution and bylaws change. This is submitted for final action by the House of Delegates.

ITEM 2: MEMBERSHIP REVISIONS RE: CITIZENSHIP; RETIRED, SERVICE, AND INTERN AND RESIDENT MEMBERS; AND JURISDICTION

The Committee submits the following *complete* revision of Chapter I, Membership, of the Bylaws pursuant to:

(a) Instructions from the 1972 House of Delegates to draft an amendment to delete citizenship as a requirement for membership; and

(b) Instructions from the 1972 House of Delegates to authorize a non-dues paying membership category for those physicians who elect to retire at any age; and

(c) Instructions from Council to draft changes in the Service membership classification; and

(d) Instructions from Council to draft changes to make interns and residents active members; and

(e) Instructions from Council to draft changes in regard to jurisdiction.

CHAPTER 1 Membership

SECTION 1. ACTIVE MEMBERS. A physician may become an Active Member in the Association if he meets the requirements of subparagraphs (a), (b) or (c) below:

(a) He shall hold the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, be licensed to practice medicine in the State of Georgia, and be certified by the Secretary of a component society as being a member in good standing of such component society; or

(b) He shall hold the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, and be employed as an intern or resident in a hospital whose internship program is approved by the Composite State Board of Medical Examiners of Georgia or any predecessor or successor body authorized to license Doctor of Medicine; and be certified by the Secretary of a component society as being a member in good standing of such component society; or

(c) He shall hold the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, be certified by the Secretary of a component society as being a member in good standing of such component society and be employed as a full time commissioned medical officer in any of the armed forces of the United States or in the United States Public Service, Veterans Administration or Indian Service.

(d) Those members classified under subparagraphs (a) and (c) above shall pay full annual dues to the Association; and those members classified under subparagraph (b) above shall pay such dues, which may be less than full dues, as the House of Delegates upon recommendation of the Council may from time to time determine. All members described in this Section 1 shall have full privileges of membership, including the right to vote, to hold office and to receive the *Journal of the Medical Association of Georgia*. A physician applying for active membership after July 1 of any year shall pay one-half of the annual dues set for the classification in which he falls.

(e) An active member may be excused from the payment of dues for the duration of any one of the following circumstances: (1) financial hardship or illness; or (2) temporary service in the armed forces of the United States during a national emergency or compulsory service under the Selective Service System or temporary service as a full time commissioned medical officer in any reserve service of the armed forces. Such relief shall not become effective until a lapse of 90 days after application therefor at which time it will become retroactive and will extend through the applicable period. Such dues exemption may be granted or denied by the Council after recommendation of the member's component local society; and the Council shall be fully empowered to grant or deny such exemption whether or not such member's constituent local society has recommended such exemption. Members excused from the payment of dues because of financial hardship or illness shall continue to receive the *Journal of the Medical Association of Georgia* without cost. The other category of active dues exempt members shall not receive any publication of the Association except by personal subscription.

SECTION 2. RETIRED MEMBERS. A member who elects to retire from the practice of medicine regardless of age or length of membership in this Association may do so and be classified as a retired member. Retired members shall not be required to pay dues, nor shall they be entitled to vote, hold office or receive any publication of the Association except by personal subscription.

SECTION 3. SERVICE MEMBERS. A physician may become a service member if he is a full time commissioned medical officer in any of the armed forces of

the United States or if he shall have retired from gainful employment as a medical officer of the United States Public Health Service, Veterans Administration, Indian Service or armed forces. Service members need not be licensed to practice medicine in the State of Georgia provided they hold the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council. Such members shall not be required to pay any dues to the Association. They shall not be entitled to vote or hold office in the Association, nor shall they receive any publications of the Association except by personal subscription.

SECTION 4. ASSOCIATE MEMBERS. A physician may be granted associate membership if he is engaged in state or county medical services or if he is a full time salaried member of an approved medical faculty in this state or who is an intern or resident in a hospital whose internship program is approved by the State Board of Medical Examiners. An associate member need not be licensed to practice medicine in the State of Georgia. Associate membership, except as otherwise provided herein, also may be granted to a member of a component medical society. Associate members shall pay no dues and shall not be entitled to vote or hold office, nor shall they be entitled to receive any publication of the Association except by personal subscription.

SECTION 5. AFFILIATE MEMBERS. Persons in the following classes may become affiliate members:

a. American Physicians, located in foreign countries or possessions of the United States, and engaged in medical missionary and similar education and philanthropic labors;

b. Dentists, who hold the degree of D.D.S., or D.M.D., who are members of their state and local dental societies;

c. Pharmacists who are active members of the Georgia Pharmaceutical Association;

d. Veterinarians who hold the degree of D.V.M. and are members of the Georgia Veterinary Association;

e. Teachers of medicine who are not eligible for active membership;

f. Teachers of, or scientists in, sciences allied to medicine and who are not eligible for active membership.

All nominations must be made by the component county medical societies and approved by the Council of MAG not later than the meeting prior to the Annual Session. A majority vote of the House of Delegates shall elect to affiliate membership.

Affiliate members shall not be required to pay membership dues, and shall enjoy the privileges of the scientific meetings without the right to vote or hold office, and shall not be entitled to receive any publication, except by subscription.

SECTION 6. HONORARY MEMBERS. Physicians and persons holding the degree of Doctor of Philosophy who have risen to prominence in their professions may be elected to Honorary Membership by the House of Delegates. Nominations for Honorary Membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy the privileges of the Association but shall not vote or hold office; nor shall they receive any publication of the Association except by personal subscription.

SECTION 7. LIFE MEMBERS. A member in good

standing who is 70 years of age may be classified as a life member and excused from the payment of Association dues and assessments upon his application to the Association through his component county society as follows: his application shall be granted in due course if such member has been continuously an active dues-paying member of this Association for 25 years; his application shall be granted in due course if he has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years provided he has been an active dues-paying member of this Association for at least 10 years of those 25 years; his application may be granted upon action of Council if he has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years but has been an active dues-paying member of this Association for less than 10 years. Service in the Armed Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned medical officer in the Reserve Armed Forces shall count as part of the period of continuous years of dues-paying membership. Life members excused from the payment of Association dues shall have the right to vote and hold office and shall continue to receive the *Journal of the Medical Association of Georgia* without cost.

SECTION 8. STUDENT MEMBERS. Any person certified by the secretary of a component county medical society to be a student member thereof may, upon such certification by such secretary, become a student member of this Association upon proof that such person is a student in good standing at a medical school approved by the State Board of Medical Examiners. Student members shall not be required to pay membership dues and shall enjoy the privileges of membership of the Association without the right to vote or hold office and shall not be entitled to receive any publication of the Association except by subscription.

SECTION 9. No person may become a member of the Association who has been judged guilty of moral turpitude or other serious crime, as determined by the Council.

SECTION 10. A member suspended or expelled from membership in the Association shall no longer be a member of the Association and shall have none of its privileges during the period of suspension or after expulsion, even though he may remain a member in good standing in a component medical society.

SECTION 11. TENURE. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the membership roll.

SECTION 12. TRANSFER. Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

SECTION 13. JURISDICTION. It shall be the policy of this Association and its component county medical societies that its members shall belong to the component county medical society having jurisdiction of the county of their predominant practice. Exceptions may be granted by Executive Committee of Council on

request from the member or members seeking an exception to this general policy; provided that society transferred to shall be contiguous to the county of member's dominant practice. When no such component county medical society has jurisdiction of the county in which a member has his dominant practice, such member shall belong to a component county medical society having jurisdiction of a county adjacent to the county in which the member has his dominant practice. This shall not necessarily be retroactive.

SECTION 14. The words "full-time" wherever used in this Chapter shall mean that no time at all is devoted to private practice.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee considered each item of the report of the Committee on Constitution and Bylaws separately and makes the following recommendations:

Item (1)—The reference committee recommends approval of the changes in Chapter IV, Section 1 of the Bylaws so that the first sentence would read as follows: "The Council is composed of the president and president-elect, immediate past president, who shall serve as a full member of Council for a period of three years, two vice presidents, secretary, speaker of the House of Delegates or vice speaker of the Delegates, past president and councilors or vice councilors selected as follows:".

The next two changes proposed concern the composition of Council, and it was felt that amendments were needed to clarify the wording in the proposed amendments.

First, the Constitution, Article 6, Section 1, is amended to read as follows: "Delegates and alternate delegates to the AMA, the treasurer, editor of the *Journal*, past presidents, other than the three immediate past presidents, and the executive director shall be ex-officio members of Council without the right to vote."

In the Bylaws, the last sentence of the last paragraph of Chapter IV, Section 1, composition is to be changed so to read as follows: "Delegates and alternate delegates to the AMA, the editor of the *Journal*, past presidents, other than the three immediate past presidents, and the executive director shall be ex-officio members of the Council without the right to vote."

It was recognized by your reference committee that these changes would result in these amendments concerning the composition of Council being delayed another year before enactment. Because of the ambiguity of the wording it was felt that it should be clarified before finally enacted. The net result will not affect the voting membership of the Council.

Item 2 concerning membership revisions, re: citizenship, retirement, service, intern and resident members, and jurisdiction. Your reference committee recommends approval of the entire chapter of the Constitution as was passed by the House of Delegates in 1972.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Constitution and Bylaws as amended by the Reference Committee.

SUPPLEMENTAL REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS

JOHN T. MAULDIN, M.D.

On May 9, 1973, Council approved for submission to the House of Delegates, the following Supplemental Report:

RESOLVED THAT Section 1 of Chapter VII of the Bylaws be amended by striking the last sentence of such section and inserting in lieu thereof the following:

"A component society shall consist of 15 or more active members, except that this limitation shall not apply to a county society possessing a county charter as of May 14, 1973."

RESOLVED FURTHER that Section 2 of Chapter VII of the Bylaws be amended by striking the fifth sentence of such section and inserting in lieu thereof the following:

"The charter of any component county society shall stand automatically revoked as of February 1 following 12 consecutive full calendar months when the total dues forwarded by the Secretary of the particular component county medical society to the Association shall constitute the dues of less than five active members or when such county society shall actually have less than five active members."

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee has carefully considered the supplemental report of the Committee on Constitution and Bylaws. Your reference committee recommends disapproval with the following recommendations. We recommend that the House of Delegates instruct the Council to visit all county medical societies with less than 15 members to encourage these societies to consolidate with adjoining county medical societies in order to form a more effective component society. Your committee has taken this action since it was felt that approval of these amendments to the Bylaws would possibly result in loss of membership in the Medical Association and possibly alienate current MAG members. Rather than revoking the charter of the component county society at the present time, it was felt that a more positive action would be to encourage these smaller county medical societies to consolidate their activities. It was also felt that after a reasonable length of time this matter could be reconsidered if such action by the smaller county medical societies was not carried out.

HOUSE OF DELEGATES ACTION—Disapproved the Supplemental Report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

COMMITTEE ON EDUCATION

J. RHODES HAVERTY, M.D.

The "umbrella" Education Committee has continued during this past year in roughly the same mold as presented to you at the last House of Delegates meeting. Sub-committees on Medicine, Nursing, and Allied Health have continued to function, headed by Drs. Edwin C. Evans, John Wilson, and John Godwin respec-

tively. Activities have occurred in almost all areas, but the most active and significant activities have been seen in the Task Force on Medical Schools of the Sub-committee on Medicine, the Task Force on Continuing Education of the Sub-committee on Medicine, and the Sub-committee on Nursing as a whole.

The Task Force on Medical Schools, headed by Dr. Robert Reynolds, had the responsibility for putting on the fifth Biennial Conference on Medical Education in February, 1973. This was an excellent conference, well attended by 60 to 80 physicians and medical students, and discussed the following general subjects over the three-day meeting: Problems in Delivery of Primary Medical Care; Quality of Medical Care and Continuing Education; Education of the Public on Health Care Needs; Emergency Medical Care. Widely recognized authorities from Georgia and the nation discussed these subjects, panel reactors helped clarify issues, and vigorous debate from the audience was the rule.

The Biennial Conference embarked on a "mini-experiment" this year, and will complete it next year. As reported to this House, this year the Conference was held at Emory, and some emphasis was given toward exposure of the Conference to the Medical School at Emory, its facilities, concerns, and plans. In addition, the entire Conference is indebted to Emory for acting as host to a delightful cocktail hour and dinner at the Top of the Mart the first evening of the Conference.

Next year, in more rapid succession than usual, the Medical College of Georgia in Augusta similarly will host the conference. At the conclusion of this conference in Augusta, some determination will be made regarding the future of the conferences as relates to timing, location, and purpose. Dr. Reynolds' report follows:

"The focus of the Task Force on Medical Schools during the current year has been the planning and implementation of the fifth Biennial Medical Education Conference in conjunction with the Medical College of Georgia School of Medicine and the Emory University School of Medicine.

"The Task Force reexamined the fundamental purposes and objectives of the conference series before formulating the program for this year. The private practitioners on the task force suggested that they (and many of their practicing colleagues) had lost contact with many of the more recent educational developments, programs and facilities at the two medical schools. After considerable discussion of this observation the Task Force decided to alter the traditional format of the conference in an attempt to address this problem.

"A decision was made to locate the 1973 Conference on the Emory Medical School campus and to plan the succeeding Conference for the *next* year (1974) on the Medical College of Georgia campus. Each hosting medical school would thereby have the opportunity to demonstrate to the conference participants some of its recent developments in medical education, medical care programs and facilities.

"Dr. Arthur Richardson, Dean of the Emory School of Medicine, and his Emory colleagues welcomed the opportunity to host the Conference for 1973 and accept the suggested format.

"Accordingly, the dates of February 23-25, 1973 were chosen and arrangements made to center the Confer-

ence on the Emory campus. Accommodations for the out-of-town participants were arranged at the Emory Sheraton Motel. Four working sessions were planned (Friday afternoon, Saturday morning, Saturday afternoon and Sunday morning). Each working session would consist of a one hour panel discussion of a selected relevant topic and a one and one-half hour group discussion period where the entire group of participants would be divided into four discussion groups, each group discussing the same topic which was addressed in the preceeding panel discussion.

"Friday night was to feature a cocktail party and dinner hosted by Dr. Richardson and a keynote address. Saturday evening the MAG was to host a cocktail party for the participants. Sunday morning was to be followed by a brief summary session.

"This format was approved by the Task Force and accepted by Dr. Richardson and his staff. Eighty participants were invited, including 40 from the MAG practicing physician membership and 20 each from the Medical College of Georgia School of Medicine and Emory School of Medicine. Several medical students from each school were also invited. The panels were selected so that representatives of each of the three groups were present on each panel.

"The panel topics, moderators and panelists were selected as follows:

1. Problems in Delivery of Primary Medical Care

Panel

William Lotterhos, M.D., moderator

Robert Jewett, M.D.

Dan Cabaniss, M.D.

Richard Blumberg, M.D.

Ollie McGahee, M.D.

2. Quality of Medical Care and Continuing Education

Panel

Kenneth H. Walker, M.D., moderator

Glen Garrison, M.D.

John McCain, M.D.

Edwin Evans, M.D.

Clark W. Mangun, Jr., M.D.

3. Education of the Public on Health Care Needs

Panel

J. Willis Hurst, M.D., moderator

Joseph Bailey, M.D.

Asa Yancy, M.D.

Gary Miller, M.D.

Joseph McNinch, M.D.

4. Emergency Medical Care

Panel

M. J. Jurkiewicz, M.D., moderator

Carl Jelenko, III, M.D.

C. Richard Baker, M.D.

Gordon Barrow, M.D.

Luther M. Vinton, Jr., M.D.

"The conference was accomplished very successfully due largely to the efforts of Dr. Richard, his staff and the MAG staff. Many laudatory comments were received from the participants regarding the conference. Free discussion, an exchange of ideas and points of view, and enumeration of many crucial issues facing both the practicing physician and the academic physi-

cian were accomplished in a most congenial, open and praiseworthy atmosphere.

"The purposes and goals of the conference appear to have been achieved. The succeeding conference is planned to take place on the Medical College of Georgia campus in the spring of 1974 with MCG acting as the host institution. The Task Force will begin its planning phase for this conference during the Annual MAG Meeting in May 1973."

Dr. Nicholas Davies has been the chairman of the Task Force on Continuing Education, of the Sub-committee on Medicine, and has been an active chairman with an interested and enthusiastic committee. One of the most notable activities of this group has been in working out the mechanism to audit continuing medical education programs in Georgia. You will recall that this House instructed the Committee on Education to implement the accreditation of continuing education programs in Georgia other than those sponsored by the two medical schools. It is anticipated that the first accrediting of a continuing medical education program will be completed in April, 1973, just prior to this Annual Session. It is hoped that a report of this particular accrediting site visit will be able to be given to this body.

In addition, Dr. Davies' Task Force has set up a fact finding sub-group to publish what kinds of continuing medical education programs exist in our state at present. It is hoped that this task will be accomplished within the next few months, which results will be published in the *JMAG*.

RECOMMENDATION

This Task Force is recommending that the MAG should encourage all hospitals within the state to establish a program of continuing medical education under the direction of a medical director, if possible, or an active continuing medical education committee of the hospital staff. It would be hoped then that such continuing education programs so established would seek accreditation by the MAG.

The Sub-committee on Allied Health has been useful in working out some of the knotty problems related to the financial problems of the Health Careers Council, and the future of the allied medical careers clubs throughout the State. It was suggested by this House last year that, with their concurrence, the Women's Auxiliary of the MAG should take back over control of these allied medical careers clubs. A good deal of negotiating has been going on among the Board of Directors of the Health Careers Council, officers of the Women's Auxiliaries of the MAG and the GHA, Dr. Godwin, and other members of the MAG. Much of the substance of these negotiations has involved budgeting concerns, and it is hoped that these will have been resolved through the MAG Council by this annual meeting. Such resolution will be reported to this House.

It should be of interest to this House that the physician's assistant law passed by the 1972 General Assembly of Georgia has been implemented. The first physician's assistants were certified by the Composite Board of Medical Examiners with the advice of members of your Education Committee in December, 1972. It is anticipated that additional physician's assistants will be certified almost on a monthly basis for the foreseeable

future. Your Composite Board of Medical Examiners is working long and hard regarding this and other matters, and is conscientiously trying to serve the needs of the people of Georgia and her physicians.

Also of interest to this House is another issue controlled by the Composite Board of Medical Examiners: viz., the taking of the first FLEX Examination by candidates for licensure as M.D.'s in Georgia this year. You will recall the law passed several years ago stipulated that 1973 would be the first year the FLEX was given, and plans are now being made for this first examination to be given in June, 1973, and thereafter.

The leaders of the sub-committees and task forces of the Committee on Education have attended state and national meetings and have been helpful to the committees because of such attendance, as well as promoting the recognition of Georgia as a leader in the health education community across the nation.

The Sub-committee on Nursing has been extraordinarily active, and has accomplished much in resolving some of the conflicts and confusion between the professions of medicine and nursing. The establishment of the Joint Practice Committee at the state level and the national level has been influenced largely by Dr. John P. Wilson's efforts. His report of his sub-committee follows these comments of mine. It is to be noted that his sub-committee is making recommendations to the House, which should be taken along with the recommendations from the Task Force on Continuing Education.

"The Sub-Committee on Nursing for the Medical Association of Georgia has been particularly active during the past year. Its activity has been primarily in its involvement with the Joint Practice Committee which has been established with equal representation by the Medical Association of Georgia and the Georgia State Nurses Association. The Chairman of this committee has attended two conferences, the Master Planning Committee and the Joint Practice Committee in Chicago on a national level and has served as a member of the faculty in a workshop on the Joint Practice Committee in Chicago in February.

"The Joint Practice Committee in the State of Georgia is relatively well advanced as compared to other states in the opinion of representatives from the two organizations. A great deal of work has been done in identifying the expanded role of the nurse and the adaptation and implications of this role in the State of Georgia. Specific areas of activity have been identified and will be promoted by the Joint Practice Committee. In addition, members of the Joint Practice Committee representing the educational aspects, both in continuing education and the nursing schools and their curriculum are participating in the development of this program in order that those responsible for education in nursing participate in this concept of the expanded role of the nurse. In addition, the legal implications of the expanded role of the nurse are being investigated and appear to present no real obstacle in the development of the program. The Joint Practice Committee has worked, and cooperated, with the Master Planning Committee and some of the members of the Joint Practice Committee are represented on both of these agencies. The following comments and recommendations are referred for specific consideration.

RECOMMENDATIONS

"1. It is requested that the House approve the establishment of a Joint Practice Committee at local levels between the local medical county or district medical society and its corresponding nurse organization. It is quite likely that in some areas there is no formal nurses' organization through which this can be done. It is, therefore, recommended that the physicians in the local area, in cooperation with the Georgia State Nurses Association, help in establishing a nurses' organization which can help to implement the expanded role of the nurse in this area, as is recommended.

"2. It is also recommended that this Joint Practice Committee establish the needs and the extent of the expanded role of the nurse in that particular area.

"3. That the House endorse the *concept* of broad practice statements referable to the expanded role of the nurse by the Joint Practice Committee, as approved by the Executive Committee of the Council of the Medical Association of Georgia. Such position, papers, or policies are designed to establish a framework within which the local Joint Practice Committee may determine the appropriate expanded role of the nurse.

"4. At the present time the ill-defined nature and role of the physician's assistant is a considerable impediment in the development of a coherent program of delivery of health care, utilizing the nurse in an expanded role. The specific role of the physician's assistant and the relationship between the expanded role of the nurse and the physician needs to be established before further activity can be carried out in this direction."

One last comment from your Chairman is that the Committee on Education will be interested in seeing the report from the Committee on Long Range Planning concerning full participation by medical students in the MAG House, and the expansion of their representation in this House. It will be recalled that this subject, a matter of discussion from this Committee in last year's House, was referred to the Committee on Long Range Planning, and we await with interest their comments as to where Georgia should go in this regard.

I have enjoyed serving as your Chairman of this important and active Committee of the Association, and am looking forward to continue to serve in this capacity during the coming year.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee has studied this report in its entirety but will confine the majority of its statements to the listed recommendations.

First, the recommendation on Page 5 of the Report of the Committee on Education which is the recommendation of the Task Force on Nursing. The reference committee recommends approval of the recommendation in the first paragraph, namely, lines 159 through 166 inclusive with the following amendments: On line 160, delete "hospitals" and add in its place "hospital medical staffs." On line 166, add "When MAG is so approved as an accrediting agency." Therefore, this recommendation would read, "This task force is recommending that the MAG should encourage all hospital medical staffs within the state to establish a program of continuing medical education under the direction of a medical director, if possible, or an active continuing medical edu-

cation committee of the hospital staff. It would be hoped then, that such continuing education programs so established would seek accreditation by the MAG when MAG is so approved as an accrediting agency."

On page 7, of the Report of the Committee on Education, Recommendations: (1) Your reference committee recommends the deletion of the last two sentences, namely, lines 261 through 268, so that recommendation (1) would read as follows: It is requested that the House approve the establishment of a Joint Practice Committee at local levels between the local county medical or district medical society and its corresponding nurse organization."

Recommendation 2: Your reference committee recommends the deletion of the word "expanded" in line 271, so that recommendation 2 would read as follows: "It is also recommended that this Joint Practice Committee establish the needs and the extent of the role of the nurse in that particular area."

Recommendation 3: Your reference committee recommends disapproval of the entire recommendation, feeling that this recommendation covers too broad an area of the role of the nurse.

Recommendation 4. Recommendation 4 actually contains no specific recommendations and therefore is accepted for information only. Your reference committee has noted the exhaustive nature of this report of the Committee on Education and commends the entire committee for its efforts in a quite comprehensive field.

HOUSE OF DELEGATES ACTION—Adopted the report on Education as amended by the Reference Committee.

RESOLUTION 73-8 ANTISUBSTITUTION LAWS

JAMES SKINNER, M.D.

DELEGATE, SPALDING COUNTY MEDICAL SOCIETY

WHEREAS, Repeal of the consumer-protective state anti-substitution laws and/or regulations has been proposed in many states over the past few years, but in *no* state has frank repeal of the anti-substitution laws or regulations been passed; and

WHEREAS, failing to obtain frank anti-substitution law repeal, those forces promoting such legislation have turned their efforts to a variety of other pro-substitution maneuvers—prior consent blanks signed at the local level, modification of State Board regulations, state formulary commission, development of a State Formulary, etc.—all of which are calculated to remove to some degree the physician's control of the therapy of his patient; and

WHEREAS, proponents of pharmacist substitution primarily promise cost savings to the patient will result, the mass of published data to date controverts any significant saving and suggests just the opposite, namely a greater expense will develop as in Alberta, Canada; and

WHEREAS, no proponents can outline *any* patient benefits likely to be derived from such maneuvers and many see the hazard of second-class therapy being fostered on our disadvantaged citizens if substitution is encouraged in any way; and

WHEREAS, any and all such maneuvers rest on the basic but now-proven-fallacious concept that chemical-



(Clockwise) Judges Keith Cowlings of Augusta College and Clemens De Baillou, Augusta Museum director, join Mrs. William Fuller in examining art show entries; Social Hour hosted by Richmond County is attended by Dr. and Mrs. Luther Thomas, president of the society, and Dr. and Mrs. Stuart H. Prather, Richmond delegate; pleased with the conclusion of a smooth-running session are J. Frank Walker, speaker of the AMA House of Delegates (L) and Preston D. Ellington, chairman of the MAG Committee on Annual Sessions; Medical Mile runners spring away from the starting line; only woman delegate, S. Charlotte Neuberg of Macon; outgoing Auxiliary President Mrs. Cliff Moore, Jr. of Rome addresses delegates.





119th Annual Session

(Clockwise) As the session begins, MAG delegates and guests are welcomed with songs by the Augusta College Choir and a special message on the side of the Richmond Motor Hotel; stopping at one of the numerous commercial exhibits is Robert F. Finegan of East Point; carefully prepared scrapbooks by Auxiliary societies are reviewed by Mrs. Charles Underwood, Marietta, Mrs. William A. Steed, Augusta, and Mrs. H. Hilt Hammett, Jr., LaGrange; panel speaker A. J. Vogl, executive editor of *Medical Economics*, compares publishing problems with MAG *Journal* editor Edgar A. Woody, Jr.



ly (generically) equivalent marketed drug products will produce therapeutically equivalent results in patients so that the cheapest is assumed to be as effective as the more expensive despite much published evidence to the contrary and despite the experience of the military's drug quality assurance program and the FDA's recall list demonstrating that marketed drug products of lower quality are available; and

WHEREAS, the Spalding County Medical Society passed a similar resolution on April 24, 1973; now therefore be it firmly

RESOLVED, that the Medical Association of Georgia resolutely and unvaryingly opposes *any* pro-substitution maneuver which in *any* way interposes *any* control of *any* third party over the physician-determined therapy of his patient without consulting with and obtaining the free approval of the specific physician responsible for that therapy; and be it further

RESOLVED, that if, despite physician opposition to such legislation, substitution *is* made mandatory on any physician to any degree, such mandatory legislation contain a clause conferring full immunity to the physician from any liability associated with any therapeutic misadventure any patient experiences related to substitution for what the physician prescribes for his patient, regardless of what terminology he uses to make his prescribing recommendation known to the dispenser; and be it further

RESOLVED, that if, despite the considered opposition by the medical profession to such legislation, it still becomes effective, it should contain clauses (a) *requiring* the pharmacist to keep records of each case in which he substitutes, (b) requiring him to report to the responsible physician immediately each time he substitutes, and (c) requiring him to keep records of his acquisition cost of the drug product substituted and the precise cost of the substituted drug product dispensed to the patient.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee has studied this resolution in detail and agreed with the basic intent in the resolution. However, the committee felt that this resolution, as submitted, was excessively verbose and complicated and therefore offers a substitute resolution that the committee feels expresses the same intent.

WHEREAS, repeal of the State Anti-Substitution Laws and/or regulations has been proposed in many states over the past few years, but in no state has outright repeal of the Anti-Substitution Laws or regulations been passed, and

WHEREAS, the Medical Association of Georgia, the Georgia Pharmaceutical Association and representatives from various pharmaceutical manufacturers have assembled a task force to study the above issue; and

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia opposes substitution therapy that would result in therapy not specifically approved by the physician prescribing said therapy, and

BE IT FURTHER RESOLVED, that the House of Delegates instruct Council to assist the above task force in whatever manner necessary in its efforts to resolve the problem of substitution therapy.

HOUSE OF DELEGATES ACTION—Adopted Resolution 73-8 as rewritten by the Reference Committee.

SUPPLEMENTAL REPORT OF THE AD HOC COMMITTEE TO STUDY MEDICAL DISCIPLINARY LAWS

C. E. BOHLER, M.D., *Chairman*

The Ad Hoc Committee to Study Medical Disciplinary Laws composed of C. E. Bohler, Brooklet, chairman; A. C. Richardson, Atlanta; William J. Morton, Cairo, president of the Composite Board of Medical Examiners; Albert M. Deal (member of the Board of Medical Examiners) (Statesboro; T. A. Sappington, Thomaston; and Robert Wells, Atlanta, has met on two occasions to develop the disciplinary procedure that would assist the Composite Board in the performance of its duty to enforce the Medical Practice Act.

After considering several approaches including a separate disciplinary board independent of the Composite Board of Medical Examiners, the Committee agreed to work for the establishment of an investigative committee that would function as an official arm of the Composite Board, hence an arm of State government.

RECOMMENDATIONS

At their last meeting on April 12, 1973 the Committee agreed to the following points subject to the approval of the MAG House of Delegates and upon written clearance of the Attorney General, establishing the legality and immunity of the members of the investigating committee:

1. To establish a medical investigative-disciplinary committee;

2. That such committee would be supplied by the Medical Association of Georgia but would not necessarily be limited to MAG members, and would consist of three physicians from each congressional district;

3. That any investigation carried out by the committee will be conducted by a minimum of three people; one of which must be a true peer of the physician under investigation, and in all cases at least two-thirds of the investigating committee will be selected by the president or vice president of the Composite Board from the committee list provided by the Medical Association of Georgia;

4. The committee may be activated only by the president or vice president of the Composite Board;

5. On request from the MAG Executive Committee, the Composite Board shall instigate an investigation unless such investigation is negated by the Office of the Attorney General;

6. Until such time as investigative experience is gained the joint secretary and/or an experienced member of the Composite Board shall accompany the committee on all investigations; and

7. The Board, in consultation with MAG, shall develop procedures by which these investigations shall be conducted;

8. The Ad Hoc Committee agreed to the above seven points within the context of its desire to be of aid and assistance to all those who hold a license to practice medicine.

The above Report is submitted to the House of Delegates with the recommendation that it be adopted

and referred to the MAG Executive Committee for implementation.

REFERENCE COMMITTEE RECOMMENDATION
Your reference committee has read with great anticipation this report concerning efforts to institute procedures of investigation in cases of disciplinary problems in the practice of medicine.

Your reference committee recommends approval with strong commendation to the ad hoc committee and with the following additions:

Item 3, line 26, change the word "people" to "physicians" so that item 3 would read as follows: "That any investigation carried out by the committee will be conducted by a minimum of three physicians, one of whom must be a true peer of the physician under investigation, and in all cases, at least two-thirds of the investigating committee will be selected by the president or vice president of the Composite Board from the committee list provided by the Medical Association of Georgia."

Addition to Item 6 so that it reads as follows: "Until such time as investigative experience is gained the joint Secretary and/or an experienced member of the Composite Board shall accompany the Committee on all investigations, the report of the investigative committee shall be filed with the Composite Board."

Item 9—Your committee also recommends that the final procedural outline including the covenant to be drawn by the various attorneys be brought to the House of Delegates in 1974 for information only.

Your reference committee would also like to comment that this particular report certainly indicates the beginning of a mechanism that fills a void that has been present in the field of medical practice for many years. It is obvious that we will have to continue to work with and develop these mechanisms to make certain that they do provide the optimum results, but we are very pleased to submit this specific report.

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report 73-1 of the Ad Hoc Committee to Study Medical Disciplinary Laws as amended by the Reference Committee. Chairman Jordan then expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee Report be adopted as a whole as amended. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE D

Beverly Sanders, M.D., Chairman

Chairman Sanders reported to the House of Delegates that the report and resolutions referred to Reference Committee D had been considered by the Committee which met at 9:00 a.m. in the Telfair Room, Richmond Motor Hotel, Augusta, Ga., on May 12, 1973. Members of the Committee present included Beverly Sanders, Jr., M.D., Macon, chairman; Luther M. Thomas, M.D., Augusta, vice chairman; Dearing A. Nash, M.D., Savannah; and Louis Felder, M.D., Atlanta.

SECOND VICE PRESIDENT

H. HILT HAMMETT, JR., M.D.

Imperfections will always be with us, but they should be a constant rebuke and challenge to the medical profession. Disinterest and apathy of physicians to participate in medical matters is a consistently present imperfection in American medicine. It is my observation that this attitude is frequently prevalent within the membership of MAG.

Without participation there will be limited communication. Without communication there cannot be understanding and support. What additional methodology the Medical Association of Georgia should promote to motivate greater participatory activity among the membership is, to me, a moot question. The individual doctor should accept this truism and need in order to prevent the continuing encroachment of bureaucratic medicine.

The old proverb "Give a man a fish and you feed him for a day; teach him how to fish and you feed him all his life" brings me to this considered recommendation.

RECOMMENDATION

MAG is only as strong as the total membership becomes actively involved in organization direction. Local county and state association leadership can plea for the support of the membership, but it really requires the pride and quality of the individual to decide whether to cut bait or fish. Every member must make that decision for himself. I recommend and ask for that active participation—NOW!

REFERENCE COMMITTEE RECOMMENDATION
—Reference Committee recommends the approval and commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second Vice President.

COMMITTEE ON COMMUNICATIONS

F. G. ELDRIDGE, M.D.

Perhaps the two most notable activities of the Communications Committee during the previous year were the Magnet Conference and the Socio-Economic Seminar, both held in Atlanta. Both conferences were well attended, and the members participating were pleased with the results. It was felt that the Communications Committee should continue to involve itself with important meetings and other activities of MAG, and add support to the planning and publicity of these meetings.

During the year, professional staff support was added at MAG Headquarters, and subsequently assigned to staff of Communications Committee. The director of public and professional relations will be charged with the on-going Communications program at the staff level. As a result of the staff addition, several things in the area of communications have been accomplished.

During the legislative session, a series of five weeks of news spot filming was accomplished. Each week, five representatives or senators were interviewed and filmed discussing a different health care bill that was pending in the General Assembly. These films were then sent to the television stations in the respective

legislator's home area. This activity was warmly received by the legislators as well as the television stations in the local area.

Through sound communications efforts, strong media relations ties have been established during the year. The Communications Committee established a media liaison program assigning a physician in five different areas of the state to serve as the local media contact representative for MAG. This was made known to the local media personnel with the offer to assist in getting statements about MAG policies, and generally answering questions about medicine on the state level. This was to be in support of local county society public relations efforts. During the year, the Communications Committee attempted to arrange with the AMA to have their Speakers and Leadership Training Conference to be held in the state. Due to a lack of interest, the conference has had to be cancelled. It is hoped that we can have another such conference during the coming year as this is a valuable piece of continuing education for MAG members and staff.

RECOMMENDATIONS

(1) It is recommended that the Communications Committee continue to play an active role in the activities of the Medical Association of Georgia, and advise Council on matters pertaining to communicating with MAG's various publics.

(2) It is recommended that the legislative news spot program be continued next year.

(3) It is recommended that the Communications Committee with professional staff intensify their internal communications effort.

(4) It is recommended that adequate finances to support these projects be given in order to build and maintain a total communications program needed for the Medical Association of Georgia. This is needed to continue to provide a public atmosphere conducive to progress and betterment for the profession in the public and the membership's eye.

REFERENCE COMMITTEE RECOMMENDATION
—Recommended that this report be approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Communications.

LIAISON COMMITTEE WITH THE GEORGIA BRANCH OF THE NATIONAL MEDICAL ASSOCIATION (GEORGIA MEDICAL ASSOCIATION)

MASON G. ROBERTSON, M.D.

As in the past, this has been an inactive Committee. We have not met and have had no correspondence with the National Medical Association.

The causes of lack of effectiveness of this Committee are not entirely clear. I think that some purpose might be served if this Liaison Committee had a specific project of mutual interest to medical organizations.

RECOMMENDATION

I would recommend that the Liaison Committee be continued and that in the coming year an effort be made to establish this Liaison Committee as an advisory committee on sickle cell anemia. This would give it some immediate practical project and if the delegates

so approve, this Liaison Committee could serve as a direct advisory body to the Governor and the State Department of Human Resources, suggesting measures that might be taken on a State level toward management of this rather tragic condition affecting as it does so many blacks.

REFERENCE COMMITTEE RECOMMENDATION
The Committee voted to approve the report and change the recommendation as follows: "It is recommended that the Liaison Committee be continued."

HOUSE OF DELEGATES ACTION—Adopted the report of the Liaison Committee with the Georgia State Medical Association as amended by the Reference Committee.

THE JOURNAL

EDGAR WOODY, JR., M.D., *Editor*

The 1972-1973 report of the *Journal of the Medical Association of Georgia* is submitted herewith:

PERSONNEL

Since our last annual report, Mrs. Rodney Phillips submitted her resignation as managing editor in order to relocate her residence to Charleston, S.C., to be near her husband who is in the U.S. Navy. Her performance as managing editor was outstanding and her resignation was accepted with regret.

We have been fortunate to secure Miss Kathy Morse as our new managing editor effective October, 1972. Miss Morse comes to us with excellent credentials. She holds a B.S. degree in journalism from the University of Florida and has had one and a half years experience as a reporter and editor for a suburban Atlanta daily newspaper. It is hoped that her tenure will be long.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

This non-profit bureau, located in Chicago, which solicits and sells advertising for the state journals, continues to serve us well. In spite of unsettled economic conditions, generally our volume of advertising has increased by a modest amount during the past twelve months. This increase is a reflection of the efforts of the Bureau's active sales force to keep in frequent contact with national pharmaceutical advertisers.

Our *Journal of the Medical Association of Georgia* now stands fourth in the country among state journals in terms of total volume of advertising pages from national pharmaceutical houses.

A nationwide seminar is to be sponsored by the Bureau this fall and will be attended by the editors and managing editors of all the state journals. This meeting is held every other year and this year we are honored to have Atlanta selected as the meeting place.

These meetings serve to keep state journal editors abreast of changes and trends in the field of medical journalism. Workshops will be scheduled as a part of the program, enabling journal personnel from the various states to exchange ideas in dealing with problems common to all journals.

CONTENTS

The *Journal* has been fortunate to have received an increasing number of papers for consideration for pub-

lication. A series of radiology conferences from Emory University School of Medicine has been particularly interesting and instructive. More of these conference transcripts are being edited and will appear in the *Journal* at an early date.

Many special articles relating to the delivery of medical care have appeared in the *Journal* during the past year. Our specialty pages continue to be timely and of excellent quality. Editorials have dealt with current problems such as physician assistants, legislative activities and PSRO.

CREDITS

Appreciation is always in order for the assistance of the Publications Committee in guiding our *Journal* policy through the year just past. Our contributing editors have continued to play a key role in carrying on the work of the *Journal*. Their contributions are vital and are much appreciated. Our President's Pages which have appeared have maintained a high standard of excellence and thanks are due Dr. Dowda for his contributions.

The Headquarters office staff with their continuing help have been vital in the publication of the *Journal* and their efforts and enthusiasm are much appreciated.

RECOMMENDATIONS

The readability of the *Journal* could be improved by more feedback from our readers in the form of letters to the editor with suggestions for improvements and features desired. We would like to solicit contributions of papers from authors who have not submitted papers before. We would like to encourage more members to let us know of their activities, awards, honors, etc., so that we may include them in our Personals section. Everyone is interested in knowing of the activities of his colleagues over the state.

REFERENCE COMMITTEE RECOMMENDATION
Recommend that this report be approved as issued.

HOUSE OF DELEGATES ACTION—Adopted the report of the *Journal of the Medical Association of Georgia*.

INTERSPECIALTY COUNCIL

THOMAS E. WHITESIDES, M.D.

In 1971, at the request of Dr. William Mitchell, then the current president of MAG, an Interspecialty Council was formed composed of the current presidents of the Specialty Societies in Georgia for the purpose of increasing liaison between the Specialty Societies and the MAG. An initial meeting was held in November, 1971, and prior to the next meeting in the spring of 1972 there was considerable turnover in the membership of this group and considerable chaos as to its organization, etc., and the already necessary change in presidents brought about a request that the current president at that time begin an investigation into changes necessary in the organization of this group to make it more effective. This culminated in a study of current activities, etc., and at the August meeting a change in format was suggested and is contained in the copy of the letter forwarded to the Executive Council of the MAG in September, 1972, as follows:

"Re: INTERSPECIALTY COUNCIL

"Dear Sirs:

"As you know, at the request of Dr. William Mitchell, then the current president of MAG, in the fall of last year an Interspecialty Council was formed composed of the presidents of specialty societies in Georgia for the purpose of increasing liaison between the specialty societies and MAG and furnishing a body for consultation and advice for the MAG in regard to whatever matters this was needed. An initial meeting was held in November and Dr. Luther Fortson was named chairman. Following this meeting, he was for health reasons forced to submit his resignation and at a meeting in the spring of this year I was elected as chairman. This was the first meeting that I attended. At that time we were requested to furnish aid to the MAG in regard to the EMCRO Project and considerable discussion ensued as to the nature of the Interspecialty Council as all members attending were in considerable ignorance concerning it and in general there was significant chaos. The feeling, due to confusion concerning several matters in which various members had had to act, I was directed to obtain whatever information I could in regard to this problem and we were to call a meeting again. Thus, on August 12, 1972, this group again met and reviewed the situation in depth going over considerable information that we had gathered from the central AMA office, information from several members personally interviewed who were involved with the Interspecialty Council of the AMA and in its formation and activities, and various other information available from other states which have set up such a council. After several hours of consideration of this material and thorough and heated discussion, we came to a rather unanimous conclusion.

"We have felt that there is considerable problem with the current organization of the Interspecialty Council. It is made up of the presidents of each specialty society and these go in and out of office at differing times of the year."

(Enclosures with above letter follow):

"The Chairman of the Council may be elected and go out of office after only one meeting. There is essentially no continuity so that there is no accrued experience developing in ways that may allow avoidance of problems the second way around or facilitate solution of problems as they occur. This has especially been brought to mind in the two areas in which the Interspecialty Council has been called in to act or to assist. These are in relation to peer review and the EMCRO Project. With adequate notice, a better input into the EMCRO Project could probably have been achieved with pre-planning and cooperation with the Interspecialty Council at an earlier date with a more efficient expenditure of time and money. In regard to peer review, the current method of appointing physicians for such committee is very desperate, irregular and in some instances inconsistent with the demographic situation and personalities involved. With more uniform organization among the specialty societies and the MAG and other medical bodies such as the Georgia Foundation for Medical Care, this can be improved.

"Future problems facing practicing physicians as it relates both to the MAG and the specialty society are certain to develop and especially in the realm of continuing education, recertification, etc. More effective

and more consistent feedback in regard to matters involving several specialties, such as Georgia Crippled Children's Division, Workmen's Compensation Laws insurance related problems and the innumerable interconnections between specialty groups, organized medicine (MAG and AMA) could be effected with better liaison. Most major Georgia specialty societies are directly tied to their national organization and the remainder likely will soon be. These organizations are tied at the national level through the Specialty Council of the AMA and other organizations are quite strong and are effective lobbying agents in many quarters. The organizations often command a high level of allegiance of their thousands of members. This allegiance extends to the parallel organization at the state level and often commands more allegiance in the higher attendance percentage at these meetings at a state and national level than at the state or local medical society level. A harnessing of this energy and loyalty in a cohesive plan vertically on a national basis and horizontally at the state level would yield a cohesive unit more able to affect and effect changes which are upon us and which challenge us in all areas of medical practice of any type.

"With these thoughts in mind the following organizational changes are suggested to the Executive Council of the MAG so that appropriate changes in the bylaws, etc., might be set up to improve the function of the Interspecialty Council in relation to the originally intended function of this Council and set groundwork for its anticipated future usefulness.

"COMPOSITION OF THE COUNCIL: The following specialty society organizations should be represented on the Interspecialty Council of the Medical Association of Georgia:

Georgia Association of Pathologists
 Georgia Society of Anesthesiologists
 Georgia Society of Dermatologists
 Georgia Academy of Family Physicians
 Georgia Society of Internal Medicine
 Georgia Chapter, American College of Physicians
 Georgia Neurosurgical Society
 Georgia State Obstetrical-Gynecological Society
 Georgia Society of Ophthalmology
 Georgia Society of Otolaryngology
 Georgia Orthopaedic Society
 Georgia Chapter, American Academy of Pediatrics
 Georgia Society of Plastic Surgeons
 Georgia Psychiatric Association
 Georgia Chapter, American Association of Public Health Physicians
 Georgia Radiological Society
 Georgia Chapter, American College of Surgeons
 Georgia Urological Association

"It was the opinion of those present that the Interspecialty Council of Georgia should be restricted to the organized specialist in Georgia and that they conform to the AMA Interspecialty Council when possible.

"REPRESENTATION ON THE COUNCIL: It should be suggested to the Specialty Societies that they select a delegate to the Council to serve a three-year term with a maximum of six years, and that an alternate delegate be selected in the same manner or be the current president of that Specialty Society.

"OFFICERS: *Chairman*—It was felt that the chair-

man of the Interspecialty Council should serve for a one-year term with the option for re-election for a maximum of two additional terms. *Secretary*—It was felt that the Secretary should serve for a two year term.

"DUTIES OF THE COUNCIL: To be of assistance to the Medical Association of Georgia in liaison between the Specialty Society and other organizations to which it might be of assistance especially in the realm of:

1. Education
2. Malpractice
3. Peer Review
4. State-Federal Programs
5. Georgia Medical Care Foundation and similar organizations
6. Interspecialty Problems at a state level

"REPRESENTATIVE LIAISON FROM THE INTERSPECIALTY COUNCIL TO THE MEDICAL ASSOCIATION OF GEORGIA: It was felt that to be effective at the state level that delegates and alternate delegates from the specialty societies to the Interspecialty Council of Georgia should become delegates and alternate delegates to the MAG House of Delegates and that the Chairman of the Interspecialty Council become a member of the MAG Council.

"MEETINGS OF THE INTERSPECIALTY COUNCIL—It was suggested that there be quarterly meetings of the Interspecialty Council in January, April, July and October.

"It was suggested that the member specialty organizations of the Interspecialty Council, through their elected leadership and executive committees, should so align themselves by their By-Laws that they might be able to take effective representative action for the specialty society between the regular meetings of the specialty society."

This report reviews in depth the problems present in the organization of the Interspecialty Council, reasons for its ineffectiveness, and the opportunities presented by this Council for improving liaison between the very active specialty societies in the state of Georgia and the MAG, realizing that this may be untapped reservoir of allegiance of active physicians which may appropriately be channeled into the related activities of the MAG. The changes that are taking place in medicine, especially as regards peer review, recertification, post-graduate training and continuing education, interspecialty problems, and the multitudinous problems affecting certain specialties or affecting several, such as legislative problems related to various aspects of the practice of medicine, are germane to such an organization. It is highly possible that more effective participation in such activities could be generated through the organization of such council.

Discussions at subsequent meetings have been related to the appropriate organizational composition, and it has been reiterated on several occasions that the unanimous consensus is that this should not be on a number basis but one-by-one organizational basis due to the large discrepancy in size of specialty groups and realizing the necessity to represent the specific problems of even the smallest group. Also, a numerical representation is already present in the structure of the House of Delegates of the MAG. Serious question of this has arisen outside the Interspecialty Council, but the member organizations have unanimously maintained the previous position.

During the year, the members of the Interspecialty Council have participated in helping appoint various committees for peer review to different organizations desiring such. Through the organization, the EMCRO project of the MAG has obtained assistance of numerous specialty groups on several occasions to assist in furnishing aid for establishing criteria for hospitalization in numerous disease states on an experimental basis. This work is progressing and is under periodic review. Problems affecting several specialties and interspecialty areas have been discussed and suggestions for solution given. This has been at the request of the Medical Care Foundation.

The Council feels that it may be of considerable use to the MAG in the future and will become a necessary liaison in many areas very rapidly. As presently constituted it is quite difficult for it to act with any continuity, and the changes suggested in the enclosed report are felt to be urgent. It is suggested that these changes be incorporated into the Bylaws or Constitution of the MAG as need be.

In order to facilitate these organizational changes Dr. Dowda, as president of MAG, froze the membership of the Interspecialty Council as of October, 1972, in order to maintain personnel continuity during this period of change.

REFERENCE COMMITTEE RECOMMENDATION —Recommend approval as issued.

HOUSE OF DELEGATES ACTION—Adopted the report of the Interspecialty Council as written.

SUPPLEMENTAL REPORT OF INTERSPECIALTY COUNCIL

THOMAS E. WHITESIDES, M.D., *Chairman*

In order to achieve the goals outlined in the original report of the Interspecialty Council (Special Report No. 73-21) it will be necessary to amend both Constitution and the Bylaws of MAG.

In as much as constitutional amendments must "lay on the table" for a full year before they can be voted on, the Interspecialty Council wishes to place before the House of Delegates the necessary amendments so that they may be acted on during the Annual Session of 1974—otherwise it will be a minimum of two years before the Interspecialty Council can come into being as provided in Special Report 73-21.

The merits, or lack of same, in organizing an on-going, viable Interspecialty Council is not the subject of this report. One wishing either to support or take exception to such a Council should address himself to Special Report 73-21. The one and only purpose of this report is to introduce now the necessary amendments to the Constitution and Bylaws so that should the House approve the report of the Interspecialty Council (Special Report 73-21) the mechanism for change will be available to be approved at the '74 House of Delegates meeting.

Accordingly, the following amendments are offered:

Constitutional Amendments

ARTICLE V, SECTION 1

Amend Article V, Section 1 of the Constitution by deleting the first sentence in its entirety and inserting in lieu thereof the following: "The House of Delegates

is composed of delegates elected by the component county medical societies and the specialty societies as provided in the Bylaws."

ARTICLE VI, SECTION 1

Amend Article VI, Section 1 by deleting the first sentence in its entirety and inserting in lieu thereof the following: "Council is composed of the president, president-elect, the immediate past president, the two preceding immediate past presidents, two vice presidents, secretary, treasurer, speaker of the House of Delegates, councilors and chairman of the Interspecialty Council as provided for in the Bylaws."

Bylaws Amendments

CHAPTER III, SECTION 2

Amend Chapter III, Section 2 by adding a new paragraph at the end as follows:

Each of the following medical specialty organizations shall elect a delegate and alternate delegate from among its membership who is and has been a member in good standing of the Medical Association of Georgia for the prior three years to serve as members of the House of Delegates:

Georgia Society of Anesthesiologists
Georgia Society of Dermatologists
Georgia Academy of Family Physicians
Georgia Society of Internal Medicine
Georgia Chapter, American College of Physicians
Georgia Neurosurgical Society
Georgia State Obstetrical-Gynecological Society
Georgia Society of Ophthalmology
Georgia Society of Otolaryngology
Georgia Orthopaedic Society
Georgia Association of Pathologists
Georgia Chapter, American Academy of Pediatrics
Georgia Society of Plastic Surgeons
Georgia Psychiatric Association
Georgia Chapter, American Association of Public Health Physicians
Georgia Radiological Society
Georgia Chapter, American College of Surgeons
Georgia Urological Association

Elected delegates shall serve a term of three years, one-third of which shall be elected annually; provided, however, that of the initial delegates elected pursuant to this provision, one-third shall serve for one year, one-third shall serve for two years, and one-third shall serve for three years. Thereafter all elected delegates shall serve a full three year term. Alternate delegates shall be the elected president of each of the medical specialty organizations enumerated above, who shall serve a term concurrent with his term as president but will not in any event serve as an alternate delegate for more than six consecutive years.

CHAPTER IV, SECTION 1

Amend Chapter IV, Section 1 by adding a new paragraph at the end of Section 1 as follows:

The duly elected chairman of the Interspecialty Council shall be a full voting member of the Medical Association of Georgia Council and shall serve a term concurrent with that of chairman of the Interspecialty Council; provided, however, that he shall be eligible to succeed himself as chairman for two additional terms only.

CHAPTER V, SECTION 4

Amend Chapter V by adding a new Section to be numbered Section 4 as follows:

SECTION 4(A)—*Election of Chairman of Interspecialty Council*: The chairman of the Interspecialty Council shall be elected annually by and from among the members of the Interspecialty Council and shall be eligible to succeed himself for two additional terms only. Election of the chairman shall be on secret, written ballots cast by an absolute majority of the delegates to the Interspecialty Council at a meeting designated by the Interspecialty Council to be an annual meeting for which a minimum of 30 days written notice shall be given to the membership of the Interspecialty Council.

SECTION 4(B)—*Election of Secretary of Interspecialty Council*: The secretary of Interspecialty Council shall be elected every second year under the same provisions governing the election of the chairman and shall serve a term of two years.

CHAPTER XI

Amend the Bylaws by providing for a new Chapter XI and by renumbering present Chapters XI through XV as Chapters XII through XVI.

Interspecialty Council

There shall be an Interspecialty Council composed of elected delegates from each of the following medical specialty organizations:

- Georgia Society of Anesthesiologists
- Georgia Society of Dermatologists
- Georgia Academy of Family Physicians
- Georgia Society of Internal Medicine
- Georgia Chapter, American College of Physicians
- Georgia Neurosurgical Society
- Georgia State Obstetrical-Gynecological Society
- Georgia Society of Ophthalmology
- Georgia Society of Otolaryngology
- Georgia Orthopaedic Society
- Georgia Association of Pathologists
- Georgia Chapter, American Academy of Pediatrics
- Georgia Society of Plastic Surgeons
- Georgia Psychiatric Association
- Georgia Chapter, American Association of Public Health Physicians
- Georgia Radiological Society
- Georgia Chapter, American College of Surgeons
- Georgia Urological Association

The elected president of each of these specialty organizations shall be a member of the Interspecialty Council and shall serve as an alternate delegate. The Interspecialty Council shall provide liaison between the Medical Association of Georgia and the organized medical specialties in Georgia and in addition shall be responsible for a broad range of activities as directed by the House of Delegates, Council, or the Executive Committee of Council.

The Interspecialty Council shall meet a minimum of once each quarter and shall make periodic reports to the Council of the Medical Association of Georgia. The Interspecialty Council shall propose an annual budget to the Finance Committee.

REFERENCE COMMITTEE RECOMMENDATION

—The Reference Committee received this report and took the following action. Recommended the approval of Article V, Section 1. Recommended approval of Article VI, Section 1. Recommended Chapter III, Section 2 under Bylaws Amendments be changed by deleting line 2 of page 2 and inserting in lieu thereof the following: "Each of the medical specialty organizations as recognized by the Specialty Boards of AMA shall elect a Delegate and Alternate Delegate. . . ." The Committee recommends that lines 7 through 25 on page 2 be stricken from the Supplemental Report. Reference Committee recommends approval of Chapter IV, Section 1 and recommends approval of the following sections: Chapter V, Section 4 and Section 4(a), and Section 4(b), and Chapter XI. Under the heading of Interspecialty Council it is recommended that the following changes be made. The report should be changed to reflect "There shall be an Interspecialty Council composed of elected Delegates from each of the medical specialty groups as recognized by the AMA Specialty Boards." It is recommended that lines 26 through 44 on page 3 be stricken from the report.

The Committee changed the last paragraph of the Supplemental Report to add clarity and continuity to the report. It is recommended that it now read as follows: "The elected president of each of these specialty organizations, through the Interspecialty Council, should serve as an alternate delegate to the Interspecialty Council." The rest of the report is approved as issued.

HOUSE OF DELEGATES ACTION—Delegate Edwin C. Evans, Fulton County, moved that lines 1 through 16 on Page 2 of the Reference Committee Report be deleted (the effect of the Reference Committee Recommendation contained in this part of the report was to eliminate from the Supplemental Report of the Interspecialty Council a listing of those specialty societies that would be represented on the Interspecialty Council and would substitute in lieu thereof inclusive language that would recognize all of the specialty boards recognized by the AMA) and reinstate the list of Georgia Specialty Societies enumerated on pages 2 and 3 of the Supplemental Report of the Interspecialty Council. A second was made to this motion. Delegate Ronald F. Galloway, Richmond County, moved to amend the previous amendment by adding to the list of specialty societies found on page 2 and 3 of the Supplemental Report of the Interspecialty Council, The "Georgia Thoracic Society." This amendment was agreed to by Delegate Evans and his second. On a voice vote the amendment was adopted.

SECRETARY

EARNEST C. ATKINS, M.D.

As my first year as Secretary nears an end, it is apparent that the activities of the Medical Association of Georgia, both in number and complexity, are continuing to expand at a very fast rate. The ability of the members of Council, Executive Committee, Committee Chairman, and the Headquarters Office Staff, to respond quickly to complex changes in new and existing programs is a matter of considerable inspiration to me.

It has been a genuine pleasure to serve with such dedicated and effective people.

1972 MEMBERSHIP REPORT

The Membership of the Medical Association of Georgia continued its upward climb during the Membership Year of 1972. Although the rate of growth did not equal the previous year, it is encouraging to observe that membership has not stagnated, but indeed continues to increase year by year. During the past 10 years—1963 through 1972—MAG has increased its membership at an average rate of 68.6 new active members per year, and an average increase of 71.2 new members representing all categories of membership. During 1972, we increased our membership in the active category by 35 and in total membership by 45. The only matter to cause any measurable concern is the loss of 23 AMA members down from 3,140 in 1971 to 3,117 in 1972. Although the number itself is not significant, the mere fact that we failed to register an increase is cause for concern and merits close monitoring in the future. A breakdown for the categories of membership for the calendar year 1972 is as follows:

1972 MEMBERSHIP REPORT

Active	3,418
DE-1	62
DE-2	31
DE-4	15
Life	184
Associate	106
Service	60
Honorary	1
Affiliate	1
Student	3
	<hr/>
	3,881

GEORGIA REGIONAL MEDICAL PROGRAM

A separate report on the activities of the Georgia Regional Medical Program will be made to the House of Delegates by the program coordinator as in years past. However, in view of the ramifications of President Nixon's budget message a phase out of the RMPs, to be completed by early 1974, seems likely, and on this basis your Secretary would like to make a few observations.

Under the leadership of Dr. J. Gordon Barrow, director of the program, the GRMP has achieved national recognition as one of the most active and effective Regional Medical Programs in the entire country. Of the 56 separate Regional Medical Programs throughout the nation, only five are associated with state medical associations as the grantee of federal funds. In a very forward thinking action by the MAG Council years ago, following the enactment of the RMP program by the Congress, MAG moved quickly to become the grantee for RMP in Georgia. The Association has been in a position to closely observe GRMP and at the same time assist the program in the area of physician acceptance, and this has proven to be mutually beneficial for both the Association and for the activities of GRMP.

Dr. Charles Adair of Washington, Ga., continues to function in the best interests of the Medical Association as the coordinator of the Georgia Regional Med-

ical Program and the profession in Georgia is indeed fortunate to have such a dedicated physician working in our best interest.

CHAMPUS PROGRAM

The CHAMPUS Program continues as a good operation and the Department of Defense, the physicians and the patients all seem well pleased with the manner in which this program has been conducted over the years. Mrs. Joyce Butler, CHAMPUS administrator and her staff are to be commended. During 1972, there was an increase in claims volume of 26 per cent. There was 67 per cent increase during 1972 over 1971 in the number of claims referred to the Review Committee. Your attention is called to the accompanying chart which reveals a rather substantial increase in all aspects of claim processing as handled by the CHAMPUS Program during 1972. MAG is one of four state medical associations that serves as the fiscal agent for the CHAMPUS program.

MAG FOUNDATION

The MAG Foundation (benevolent) grows continually. The bank balance as of December 31, 1971 was \$7,303.50 and increased to \$8,411.66 as of December 31, 1972.

There will be included in the 1973-74 Budget of the MAG an amount equal to \$1.99 per dues paying member to be allocated to the Foundation in order that a fund may be established to assist indigent physicians and physician's widows. This amount will be shown in the Foundation Funds after June 1, 1973.

I know I speak for the entire Foundation when I express gratitude to the various county society women's auxiliaries for their numerous contributions to the Scholarship Fund administered by the Foundation.

The activities of the Foundation are governed by a six man Board of Trustees. The current Board and the expiration date of their terms is as follows:

- John T. Mauldin, M.D., President—1973
- J. Frank Walker, M.D., Vice President—1974
- Mr. James M. Moffett, Secretary-Treasurer—1976
- Mr. Everett Williams—1975
- Charles R. Andrews, Jr., M.D.—1977
- J. Rhodes Haverty, M.D.—1978

HEADQUARTERS OFFICE

The Headquarters Building continues to serve as a very adequate focal point for the operations of the Association. With the possible phase out of the GRMP Program, space in the Headquarters Office which was becoming scarce, will cease to be a problem.

Our Headquarters Office Staff is continually growing in response to an enlarged membership and a vastly increased number of projects and activities. The total personnel at MAG and the various related activities that are sponsored by MAG is 98. A breakdown of the personnel by departments is as follows:

Georgia Regional Medical Program	40
CHAMPUS	15
Georgia Medical Care Foundation	16
Medical Association of Georgia	15
EMCRO	12

There has been a considerable turnover of personnel in the MAG Headquarters Office since the summer of 1972. New additions to the secretarial staff include Mrs. Delores Corbier, Mrs. Susan Thompson, and Miss Theda Mason. MAG also has a new, exceptionally fine managing editor of the *Journal*, Miss Kathy Morse. Mr. Rusty Kidd was retained as MAG's legislative representative and has done an unusually fine job. Mr. Charles Templeton, employed as director of public and professional relations for MAG, represents the only true addition to the MAG Staff. The previously named individuals are replacements for persons no longer with the staff or who are functioning in a different capacity. In spite of the fact that six of MAG's 15 employees are new personnel (the combined total length of service as of March, 1973 was 32 months—an average of five months each) the operations of the Headquarters Office, the programs and projects of MAG continued to function smoothly and in a manner that reflects credit on the profession and its association.

RECOMMENDATIONS

Expanding members is a vital concern of MAG as well as to our component Medical Societies. Accordingly, I would like to recommend that Executive Committee be instructed to appoint a special Committee on Membership to oversee implementation of an organized program of membership recruitment.

REFERENCE COMMITTEE RECOMMENDATION
Recommend approval with commendation.
HOUSE OF DELEGATES ACTION—Adopted the Report of the Secretary with commendation.

COUNCILOR OF RICHMOND COUNTY
MEDICAL SOCIETY

RONALD F. GALLOWAY, M.D.

Although I have served on Council in the past as vice president of the Medical Association and then as vice councilor to Dr. Joseph Mulherin, this Annual Session of 1973 completes my first year as Councilor from the Richmond County Medical Society. My society has been represented at each Council meeting either by me or by my able vice councilor, Dr. Henry Scoggins.

My one regret during this first year as Councilor is that the seminar I had arranged on the Socio-Economics of Medicine scheduled for February 17 in Augusta had to be cancelled because of an almost complete lack of response by those students, interns, and residents invited. I feel that they would have benefitted greatly from the knowledge and experience which the panel members had so willingly agreed to share.

I have made it a point to give an oral report of the highlights of the Council meetings I have attended to my society at the meeting of the society immediately following the Council meeting, and thus issue my one recommendation:

RECOMMENDATION

I recommend that each councilor or vice councilor be encouraged to present a verbal report of the previous Council meeting to his medical society at the next meeting of his society following the Council meeting. This would enhance communications between the Council and the local societies.

GEORGIA 1972									
CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES									
STATISTICAL REPORT									
Claim Flow	Annual		% Totals		Average Per Month		Average Per Day		Annual Increase or Decrease
	1971	1972	1971	1972	1971	1972	1971	1972	
I. No. claims received									
1. Inpatient*	29,514	30,954	51.5	42.9	2,459.5	2,579.5	116.66	122.35	4.88 +
2. Outpatient*	22,248	30,903	38.8	42.8	1,854.0	2,575.3	87.94	122.15	38.9 +
3. Drugs†	5,533	10,271	9.7	14.3	461.1	855.9	21.87	48.59	85.63 +
Total	57,295	72,128	100	100	4,774.6	6,010.7	226.46	285.09	25.88 +
II. Returned	7,154	8,439	12.5	11.7	596.17	49.66	28.28	33.36	17.96 +
III. Rejected	5,307	6,794	9.3	9.4	442.25	36.83	20.97	26.85	28.02 +
IV. Review Committee	61	102	.001	.001	5.08	8.5			67.21 +
V. Number claims paid									
1. Regular	41,019	45,328	81	75	3,418	3,777.3	162.13	179.16	10.505+
2. Handicap	1,060	1,025			88	85.4	4.19	4.05	3.302-
3. Drugs	4,650	6,911	84	67	388	575.9	18.38	27.32	48.62 +
Total	46,729	53,264	82	73.8	3,894	4,438.7	184.70	201.53	13.98 +
VI. Funds disbursed									
1. Regular	\$4,281,675.14	\$4,317,461.76	88.4	88.4	356,806.26‡		359,788.48§		0.83 +
2. Handicap	408,232.12	363,552.38	8.4	7.5	34,019.34		30,296.03		1.09 -
3. Drugs	156,839.08	201,293.17	3.2	4.1	13,069.92		16,774.43		28.34 +
Total	\$4,846,746.34	\$4,882,307.31	100	100	403,895.53		406,858.94		0.73 +
VII. Funds disbursed per claim									
1. Regular	\$104.38	\$95.25							
2. Handicap	385.12	354.68							
3. Drugs	33.73	29.13							
Total	\$103.72	\$91.66							

* Includes Handicap Claims
† Includes Consolidated Reimbursements—Vendor Drugs
‡ Average per month—1971
§ Average per month—1972

TENTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1971		Members December 31, 1972	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Richmond				
J. K. McDonald				
Augusta	308	264	308	266

REFERENCE COMMITTEE RECOMMENDATION

—Reference Committee recommends approval.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Richmond County Medical Society Council.

SPEAKER AND VICE SPEAKER

HARRISON L. ROGERS, M.D.

The House directed in 1972 that the Delegates Informational Handbook be included in the permanent part of the Delegates' Handbook and this has been accomplished. In addition, your speaker and staff have reviewed all directions of the House and find that all have been implemented. A review of the directions of the House has been presented at each Council Meeting until complete.

As directed last year, a Socio-Economics Seminar was arranged in Atlanta and in Augusta, both to have been held in February. The Augusta meeting was cancelled because of a poor response to our questionnaire. The Atlanta meeting was held with an excellent panel of speakers who donated their time, including physicians, lawyers, bankers, and accountants. This meeting was very poorly attended and raises doubt as to the wisdom of the presentation. The practical aspect of starting practice including financing, bookkeeping, insurance and physician relationships were all covered by experts. The afternoon program was followed by a social hour for the participants and their wives.

Once again this year, the Speaker has appointed the committee to consider the budget and methods of financing it prior to this session of the House. This was named Reference Committee "F" last year. A similar committee has been appointed this year and will be prepared to deal with the finances of the Association by virtue of their prior study of the budget, etc.

RECOMMENDATIONS

1. That the House direct the annual appointment of a Reference Committee "F" to examine the budget and receive financial reports prior to the annual session. That the Speaker submit to this committee all financial reports or requests for expenditures reviewed by the House.

2. That a final effort be made by the Communications Committee to produce an effective Socio-Economic Seminar. If this effort is again poorly received, this seminar should be discontinued.

3. That in view of the multiple complaints raised by the public concerning "access to health care," some method be devised within the Association to identify the areas of our State where access to care is a problem. The Council of MAG should be given such data for its action.

REFERENCE COMMITTEE RECOMMENDATION

—Reference Committee recommends that approval

be given to the report and Recommendation 1. The following changes are recommended for the last two parts of the recommendations. Recommendation 2 should now read as follows: "Since the efforts to produce an effective Socio-economic Seminar for medical students and those in graduate medical education have thus far been relatively unsuccessful, it is recommended that the matter be referred to the Communications Committee for study and proposal of a different methodology." Under Recommendation 3, it is recommended that strong emphasis be placed on this recommendation and the following amendment is recommended. That the President appoint an Ad Hoc Committee on Access to Health Care to develop the methodology and implementation of this project.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Speaker and Vice Speaker as amended by the Reference Committee.

THE STATE OF THE MEDICAL ASSOCIATION OF GEORGIA

F. W. DOWDA, M.D., *President*

Having been your President for the past 12 months, I now have the privilege of bringing you a report on my stewardship which I have served for you.

I. FINANCIAL:

Due to a wise policy adopted, your Council refers the budget of the Medical Association of Georgia to this House of Delegates for approval and adequate funding on a year-to-year basis or reduction of that budget to levels which will be accommodated by current income without a dues raise. Due also to wise financial activity of Council, MAG income outside of dues has increased over the last several years and should continue to do so. This should permit continued expansion of the program of MAG and continued increase in services to MAG members for several years to come without a dues increase.

II. POLITICAL:

A. *City and County*: Generally speaking, our Medical Association of Georgia doctors have continued to be good citizens and have participated actively in county and city governments throughout Georgia and as a result local relations are strong and good.

B. *State*: After a rather disastrous year in the legislature in 1972, MAG got up off the ground, shook the blood out of its eyes, re-evaluated its objectives and, I believe, has begun to have a mature and warm relationship with state government. Heartly congratulations are due Harrison L. Rogers, M.D., James A. Kaufmann, M.D., Mr. James M. Moffett, and Mr. Rusty Kidd, for their activities in this area.

C. *National*: The appointment of Senator Herman Talmadge to the chairmanship of the Health Subcommittee of the Senate Finance Committee is a boon to the health needs of America. This highly intelligent, thoughtful, reasonable man will add a balance to health legislation that I feel will maintain the best of the past while making the necessary adaptations to accommodate the future needs of the nation in this critical area.

III. ADMINISTRATIVE:

Although Mr. James M. Moffett and Mr. Adam Jablonski and the remainder of the MAG staff have done outstanding jobs, the need for additional skilled personnel as a part of the Medical Association of Georgia staff and its subsidiary operations, such as, the Foundation, EMCRO, CHAMPUS, etc. remains a real stumbling block to our reaching our full potential.

In this area the need for research and development personnel in the field of peer review, post-graduate education and self-evaluation procedures is most acute.

IV. BUILDING AND GROUNDS:

At this time it is probably unwise to further expand the current MAG building. This should not be ruled out for the future, however, nor should a move to the perimeter be excluded from our thinking. The potential of rapid change in property values should be kept in mind in these deliberations.

V. COMPONENT SOCIETIES:

The real strength of the Medical Association of Georgia, to me, is in a diffusion of this power out into the county medical societies, strengthening those that are already strong and rebuilding those which have become ineffectual. This must be one of the primary objectives of MAG. Contrariwise the political statesmen in the county societies must not forget that MAG is a reflection of their collective strengths and this reflection is frequently able to accomplish various activities unavailable to them as a single unit.

VI. PROGRAMS:

MAG has been strong in the program area.

A. *Foundation*: The Foundation activity has brought credit to the medical profession. The state of Foundation art remains crude, rudimentary, and abrasive; however, I remain convinced that if medicine is to survive the ever-increasing threat of governmental bureaucracy it will be in the Foundation mechanism.

B. *EMCRO*: The EMCRO is a federally funded research and development effort to promulgate quality medicine. Like the Foundation, it holds certain dangers for us. However, the rubber raft through the white waters of the river is less dangerous than the death by starvation at the bottom of the canyon. So I feel we must proceed, aware of the dangers inherent in health programs.

C. *Insurance*: As with many state and county medical societies, our insurance program is ailing. It is so sick, in fact, that your Council has recently recommended a switch to the Southern Medical Association Program. This worries me because I am not convinced in this day and time that organizations such as the Southern Medical Association are truly viable entities. They may be—they may not be. We must seek some other alternatives to this approach in which viability seems reasonably assured.

I feel that our professional liability insurance rates should begin to drop within the next two years.

RECOMMENDATIONS

I would recommend against any major bylaws changes within the next three years.

I would recommend we continue to emphasize the following three things:

1. Beefing up the county medical societies.
2. Improved services to our physician members.
3. A continuation of the ongoing effort of improving quality of care to the patient.

REFERENCE COMMITTEE RECOMMENDATION

—It is recommended that this report be approved with commendation and with deletions in the following recommendations: "It is recommended that lines 19 and 20, page 3, be stricken from the report."

HOUSE OF DELEGATES ACTION—Adopted the Report of the President with the deletions recommended by the Reference Committee.

SUPPLEMENTAL REPORT OF THE COMMUNICATIONS COMMITTEE

ROBERT P. WIGHT, M.D., *Chairman*

Throughout the history of the Medical Association of Georgia, practitioners have been concerned about public attitudes and misconceptions of the profession. It has been organized medicine's place to present fair and objective information to the public while providing the necessary benefits to its membership.

As we have experienced the evolution of electronic media, we have also noted the increased interest and knowledge of the public about matters of concern to them. For this reason among others, we have had to develop more effective ways of developing communications efforts in order to keep pace with the public's thirst for knowledge and developing strong lines of defense against errors in fact.

It is an established fact that the essence of viable association growth lies in its communications efforts. Therefore, it is incumbent upon all association members to pledge themselves to develop more effective ways of communicating both within the profession and to the general public. It is with these facts in mind that the following observations are proposed for consideration and implementation.

The Communications Committee has reviewed at great length the assets and liabilities of the California-developed Tel-Med audio information system.

This system provides health care information for the community as well as extends the physician's capabilities as the teacher of health care matters. Through a system of pretaped messages recorded on cassettes, an individual can call a specified number and hear 3 to 5 minute messages on a variety of health care subjects. These subjects run the gamut from birth control to the use and abuse of various types of drugs. Currently the standard bank of tapes numbers 120. This system could be well used in Georgia to provide the public with needed information about health care matters as well as derive infinite public relations benefit for the medical profession in Georgia.

In the committee's opinion, this system could be effectively set up on a state wide basis using an 800 wide area telephone service (WATS) number to cover the state. Based on the successes experienced in California and other states with the program, we are convinced that Tel-Med would be well publicized by the news media and well received by the public.

The most current figures available to us would show that to implement Tel-Med in Georgia the first year, the program would cost roughly \$40,000. Within this figure would be the cost of the basic equipment and

basic library of 120 tapes, services of an operator to man the switchboard system, costing of the telephone service for the year and various other fiscal requirements such as rent, postage and maintenance. After the first year, it is estimated that the cost of operating the Tel-Med system would be reduced by some \$10,000.

The Communications Committee respectfully requests consideration by the House of Delegates for the following three items:

RECOMMENDATIONS

It is requested that the House of Delegates endorse the Tel-Med project for Georgia. It is also requested that the House of Delegates give a commitment for the implementation of this program. Thirdly, it is requested that the House of Delegates give to Council the authority and responsibility to develop the financial requirements and funding for the Tel-Med program, this to be done prior to Annual Session—1974.

REFERENCE COMMITTEE RECOMMENDATION
—Reference Committee reviewed the Supplemental Report of the Communications Committee and in the paragraph on page 2 starting on line 9 should read: "To implement Tel-Med in the Metro-Atlanta toll-free area the first year," and continuing with the report down to line 17. It is recommended by the Committee that lines 18 through 28 not be approved and that this report should be referred to the Communications and Finance Committees for further study. A report is to be made to the House during the next Annual Session.

HOUSE OF DELEGATES ACTION—Disapproved the recommendations contained in the Supplemental Report of the Communications Committee and adopted the recommendation of the Reference Committee to refer the report to the Committees on Communication and Finance for further study.

**RESOLUTION 73-7
RECOMPOSITION OF COUNCIL**

JOHN H. DEATON, M.D.
MUSCOGEE COUNTY MEDICAL SOCIETY

WHEREAS, the leadership of the Medical Association of Georgia has encouraged liaison between specialty societies and the Medical Association of Georgia; and

WHEREAS, it is desirable to have representation of all specialty groups in the MAG; and

WHEREAS, it is the goal of the MAG to be truly representative of all physicians in Georgia; and

WHEREAS, the trend in Medicine for the past two decades has been toward specialization; therefore be it

RESOLVED that the composition of the MAG Council be adjusted to allow a representative of each specialty represented on the Interspecialty Council as a member of the MAG Council.

REFERENCE COMMITTEE RECOMMENDATION
—Reference Committee recommends disapproval of this resolution.

HOUSE OF DELEGATES ACTION—Disapproved Resolution 73-7—Recomposition of Council as recommended by Reference Committee.

Chairman Sanders then expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the report be adopted as a whole as amended. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE F

James H. Manning, M.D., *Chairman*

Chairman Manning reported to the House of Delegates that the Reports and Resolutions referred to Reference Committee F had been considered by the Committee which met at 9:00 a.m. in the Fenwick Room, Richmond Motor Hotel, Augusta, Ga., on May 12, 1973. Members of the Committee present included James H. Manning, M.D., Marietta, chairman; John S. Atwater, M.D., Atlanta, vice chairman; Duane Blair, M.D., Decatur; Robert D. Waller, M.D., Albany; James H. Sullivan, M.D., Columbus; and Stuart Prather, M.D., Augusta.

**WOMAN'S AUXILIARY TO
MEDICAL ASSOCIATION OF GEORGIA**

MRS. CLIFF MOORE, JR., *President*

"Communicate Contagious Space Age Culture" was the theme of the Woman's Auxiliary to the Medical Association of Georgia for 1972-73. County auxiliaries have displayed much enthusiasm in developing this theme within their own communities, with research into needs, and plans for implementing those needs with programs.

To the Medical Association of Georgia and its entire staff, Dr. F. G. Eldridge, chairman of the Advisory Committee and members of the Advisory Committee, the Auxiliary wishes to express its appreciation for all the help and support it received in achieving the aims and goals for the year.

The State Auxiliary is made up of 38 component county auxiliaries with a membership of 2,512 members. Membership is always an important factor in the lifeblood of growth and success. The total program includes AMA-Education and Research Foundation, Legislation, Health Manpower, International Health, Health Education, Health Services Activities.

The MAG House of Delegates requested the Auxiliary to take the responsibility to help run the Allied Medical Career Clubs in Georgia which was accepted with enthusiasm. A proposed annual budget was submitted to set up an Auxiliary office in the MAG Headquarters Building for the Allied Medical Career Clubs, which was approved by March Council Meeting. The Georgia Hospital Association has agreed to assume responsibility for printing all letters, AMCC Newsletters, and necessary printed matter for the Auxiliary. They also will supply all paper. Mr. Reginald R. Capes agreed to contact appropriate members of the Georgia Hospital Association to solicit their help in planning programs and serving on committees with the WaMAG.

One dollar from each registration at the Teenage Nutrition Conference goes toward the AMCC Scholarship Fund. MAG approved at the March Council meeting \$250 matching funds for AMCC scholarship given at their annual convention held April 6-8, 1973 at Rock Eagle. The Auxiliary helped with the Scholar-

ship and Awards Committee, judged with the Scrapbook Committee as well as served as volunteers for conference registration and pre-conference registration—recognizing that we can improve the image of medicine and enhance a higher quality of life by investing in our youth.

County auxiliaries are active in support of Health Career Clubs and Junior Volunteers and sponsored "Tour and See" days in local hospitals. A Health Careers Library open to interested students is in its third year of operation. Each auxiliary was urged to place Allied Health Careers Directory from AMA in their high schools.

The AMA requested that we undertake a survey of medical needs and resources in each community to ascertain the advantages and disadvantages of living in cities and rural areas, and to alert small communities as to what they might do to attract physicians.

Assistance and financial aid to WA-Student American Medical Association chapters were given to help with their regional meeting and projects. Auxiliaries helped in gathering information on Georgia medical training centers for the National Housing Information System for interns and residents.

The William R. Dancy, M.D. Student Loan Fund, is one of the most valuable endeavors the Auxiliary undertakes, is supported by contributions and memorial gifts and is now worth \$50,448.50. Three loans were made for 1972-73 which amounted to \$3,100.00.

Contributions to AMA-ERF to help support medical schools and provide a Student Loan Guarantee Fund have an estimated total of \$10,000 with many fundraising events still to be reported.

The Legislation Committee has been quite active this year being election year. November 7 was proposed as a red letter day to vote for the candidates who would support and express medicine's point of view. We promoted legislation that would keep the practice of medicine open and retain the doctor-patient relationship. We stressed the importance of being well informed about legislation, prodding for activism of MAG sponsored bills and emphasizing the necessity of "getting to know" our representatives. We participated in the Georgia Legislative Forums and Seminars. Urged each member to join GAM-PAC and become more involved in the political arena. Wa-MAG observed Legislature Day at the State Capitol on February 12.

Support for the Ship Hope, contributing to An Lac Orphanage in Saigon, Scholarship for Kids of International Physicians (SKIP Project), the collecting of drug samples and other medical supplies, entertainment of foreign doctors, wives and students were some of the International Activities.

Mrs. Annette L. Sage of the Georgia Society for the Prevention of Blindness at the Wa-MAG Winter Board Meeting gave an informative address on amblyopia

and how to enlist and train volunteers to conduct vision and hearing screening test in their counties. The State Legislature passed a bill requiring vision, hearing and dental screening certificates before first grade entry September 1973.

Other outstanding projects encompass courses on Medical Self-Help, Emergency Services Program by sponsoring the publication and distribution of a booklet entitled A.I.D., a Blood Assurance Plan, VD education in high schools, drug use and abuse, Cancer Education kits and pamphlets, Safety Hazards, Physical Fitness Tests; Planned Fat-Low Cholesterol Diet Classes; and a Pap Smear Program for Rural Women, and many others were implemented by auxiliaries.

As President, I wish to commend those concerned members of the Woman's Auxiliary to the Medical Association of Georgia for a superb job this year.

RECOMMENDATIONS

The Woman's Auxiliary to the Medical Association of Georgia recommends that:

Auxiliary dues be included in the central billing of physicians by MAG.

County medical societies with membership of ten or more encourage their wives to organize county auxiliaries.

Inclusion in MAG Directory a list of the Auxiliary officers and addresses.

A proposed annual budget be allocated the Allied Medical Career Clubs, as requested by Dr. Rhodes Haverty at the March Council Meeting. The MAG House of Delegates requested the Auxiliary to take the responsibility to help run the Allied Medical Career Clubs in Georgia. The Auxiliary would maintain and fulfill the duties of the AMCC.

REFERENCE COMMITTEE RECOMMENDATION
—Your Committee recommends approval of recommendation 1, with the additional recommendation of the Committee that staff be instructed to proceed with implementation of the voluntary dues inclusion in central billing at the earliest possible date. It is recognized by the Committee that this may not be feasible for the next billing.

On recommendation 2 and recommendation 3, lines 6 through 9, your committee recommends approval.

On recommendation 4, your Committee recommends approval of this recommendation, recognizing that this proposal has already been included in the 1973-1974 Budget.

Our Association, as always, is indebted to the Auxiliary for their help, and the Committee seeks their continued support.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Woman's Auxiliary to the Medical Association of Georgia.

COMMITTEE ON FINANCE
F. G. ELDRIDGE, M.D., *Chairman*

SUMMARY-COMPARISON OF BUDGETED & ACTUAL OPERATIONS

MEDICAL ASSOCIATION OF GEORGIA
Period June 1, 1972 to April 30, 1973

	<i>Budget</i> 6/1/72 5/31/73	<i>Actual</i> 6/1/72 4/30/73	<i>(Over)</i> <i>Under</i> <i>Budget</i>	<i>'73-'74</i> <i>Proposed</i> <i>Budget</i>
INCOME				
1. (a) MAG Dues	\$320,000.00	\$340,690.00	\$(20,690.00)	\$330,000.00
(b) Interest & AMA	11,000.00	19,326.03	(8,326.03)	14,000.00
(c) FP Service	3,250.00	2,979.13	270.87	3,250.00
(d) Parking	6,000.00	6,390.50	(390.50)	7,000.00
2. ANNUAL SESSION	7,000.00	6,300.00	700.00	
3. JOURNAL	46,000.00	40,936.70	5,063.30	49,000.00
4. RENT		1,300.00	(1,300.00)	
5. CONTINGENT-Trans. from Opr. Cap.	16,240.00		16,240.00	69,800.00
TOTAL INCOME & CONT.	\$409,490.00	\$417,922.36	\$ (8,432.36)	\$473,050.00

EXPENSE				
1. (a) Fixed Allotments	\$102,945.00	\$ 91,025.22	\$ 11,919.78	\$104,253.00
(b) Association Office	158,220.00	139,348.66	18,871.34	215,579.00
(c) Association Comm.	61,645.00	34,911.79	26,733.21	61,293.00
(d) Related Activities	3,925.00	2,937.40	987.60	4,425.00
(e) Executive Comm. Disc. Fund	1,000.00	214.72	785.28	1,800.00
(f) CONTINGENT-Trans. from Oper. Cap.	10,000.00	8,991.67	1,008.33	10,000.00
2. JOURNAL	56,455.00	51,553.75	4,901.25	58,100.00
3. DEPRECIATION:				
Building	15,000.00	13,750.00	1,250.00	15,000.00
Equipment	300.00	275.00	25.00	2,600.00
TOTAL EXPENSE	\$409,490.00	\$343,008.21	\$ 66,481.79	\$473,050.00

	<i>30 April 1973 (%)</i>	<i>30 April 1972 (%)</i>
LIQUID FUNDS AVAILABLE		
C & S Checking Account	\$ 56,040.23	\$ 50,717.48
C & S Certificates	456,074.81 (7.05%)	110,000.00 (4.5%)
Decatur Federal		200,000.00 (5.5%)
	\$512,115.04	\$360,717.48
Funds include Restricted Monies:		
Regular	\$ 30,000.00	
Building Depreciation	49,600.00	
Equipment Depreciation	1,242.79	
	\$ 80,842.79	

1. (a) FIXED ALLOTMENTS				
Interest & Prin. on Mort.	\$ 54,495.00	\$ 49,953.75	\$ 4,541.25	\$ 39,495.00
Attorney & Retainers	14,000.00	7,421.87	6,578.13	14,000.00
President's Honorarium	2,400.00	2,400.00		2,400.00
Annual Audit	2,700.00	2,685.00	15.00	2,700.00
Taxes	21,000.00	21,000.00		21,800.00
Retirement Contribution	3,600.00	3,175.96	424.04	9,908.00
Retirement Trust Fee	250.00		250.00	250.00
Woman's Auxiliary	4,500.00	4,388.64	111.36	10,500.00
MAG Foundation, Inc.				3,200.00
TOTAL FIXED ALLOTMENTS	\$102,945.00	\$ 91,025.22	\$ 11,919.78	\$104,253.00
(b) ASSOCIATION OFFICE				
Salaries	\$130,000.00	\$130,000.00	\$	\$182,930.00
Insurance & Bonds	9,000.00	8,445.89	554.11	8,500.00

	Budget 6/1/72 5/31/73	Actual 6/1/72 4/30/73	(Over) Under Budget	'73-'74 Proposed Budget
Payroll	6,500.00	6,500.00		9,094.00
Travel-President	3,000.00	990.01	2,009.99	2,000.00
Travel-President Elect	1,200.00	735.00	465.00	1,250.00
Travel-Past President	1,200.00	1,168.78	31.22	1,250.00
Travel-Office	11,750.00	11,147.11	602.89	12,000.00
Travel-Executive Comm.	4,800.00	2,122.57	2,677.43	2,200.00
Travel-Delegates & Sec. to AMA Meetings	6,000.00	4,798.18	1,201.82	5,200.00
Travel-Alt. Delegates & Treas. to AMA ..	4,500.00	1,962.30	2,537.70	4,800.00
Macon Office Rent	1,440.00	1,200.00	240.00	1,440.00
Maintenance				
Building	2,750.00	3,097.01	(347.01)	2,750.00
Equipment	1,000.00	673.46	326.54	1,000.00
Telephone & Telegraph	4,500.00	5,318.53	(818.53)	8,600.00
Postage	7,000.00	5,326.49	1,673.51	7,000.00
Office Supplies	6,000.00	5,785.38	214.62	6,000.00
Janitor Service, Supplies and Security	8,800.00	7,024.17	1,775.83	8,200.00
Meetings	2,000.00	1,905.14	94.86	1,800.00
Dues & Subscriptions	580.00	533.86	46.14	765.00
Utilities	10,000.00	9,301.29	698.71	10,000.00
Sundry	200.00	50.65	149.35	200.00
Equipment	1,000.00	808.70	191.30	3,600.00
	<u>\$223,220.00</u>	<u>\$208,894.52</u>	<u>\$ 14,325.48</u>	<u>\$280,579.00</u>
Reimbursable Expense	65,000.00	69,545.86	(4,545.86)	65,000.00
TOTAL ASSOCIATION OFFICE	\$158,220.00	\$139,348.66	\$ 18,871.34	\$215,579.00

(c) **ASSOCIATION COMMITTEES**

<i>Standing</i>				
Annual Session-Business	\$ 17,535.00	\$ 5,514.10	\$ 12,020.90	\$ 7,375.00
Annual Session-Scientific				2,550.00
Emergency Medical Svc.	700.00	158.95	541.05	250.00
Professional Conduct	590.00		590.00	.00*
<i>Special</i>				
Awards	400.00	252.52	147.48	400.00
Blood Banks	50.00		50.00	
Cancer	400.00		400.00	.00*
Communications	4,750.00	3,353.81	1,396.19	21,920.00
Ecological Health	700.00		700.00	
Education	3,000.00	1,924.60	1,075.40	2,823.00
Government Prog. & Med. Svc.	1,500.00	814.27	685.73	
Historical	50.00		50.00	
Insurance & Economics	1,625.00	1,294.20	330.80	2,550.00
Legislation	8,200.00	8,110.40	89.60	10,000.00
Long Range Planning	3,000.00		3,000.00	.00*
Maternal & Infant Welfare	150.00	28.73	121.27	.00*
Medicine & Religion	150.00	56.71	93.29	150.00
Mental Health	650.00		650.00	.00*
Occupational Health	275.00	201.00	74.00	.00*
Peer Review	750.00		750.00	825.00
Physician-Lawyer Liaison	50.00		50.00	.00*
Private Practice	50.00		50.00	.00*
Quackery	12,000.00	9,019.54	2,980.46	6,500.00
Rural Health	1,520.00	1,295.22	224.78	1,450.00
School Child Health	2,000.00	1,387.74	612.26	1,500.00
Talmadge Hospital Liaison	50.00		50.00	
Contribution to GaMPAC	1,500.00	1,500.00		3,000.00
	<u>\$ 61,645.00</u>	<u>\$ 34,911.79</u>	<u>\$ 26,733.21</u>	<u>\$ 61,293.00</u>
TOTAL ASSOCIATION COMMS.	\$ 61,645.00	\$ 34,911.79	\$ 26,733.21	\$ 61,293.00

(d) **RELATED ACTIVITIES**

AMA Delegates Group Cost	\$ 2,700.00	\$ 2,686.66	\$ 13.34	\$
1. Breakfasts				1,000.00
2. Hospitality Suite				1,300.00

	<i>Budget 6/1/72 5/31/73</i>	<i>Actual 6/1/72 4/30/73</i>	<i>(Over) Under Budget</i>	<i>'73-'74 Proposed Budget</i>
3. S. E. States Suite				900.00
Interprofessional Council	125.00	125.00		125.00
SAMA	500.00		500.00	500.00
SAMA-MAG Annual Session	450.00		450.00	450.00
SMEB	150.00	125.74	24.26	150.00
TOTAL RELATED ACTIVITIES	\$ 3,925.00	\$ 2,937.40	\$ 987.60	\$ 4,425.00
(e) EXECUTIVE COMMITTEE				
Discretionary Fund	\$ 1,000.00	\$ 214.12	\$ 785.88	\$ 1,000.00
Committee Discretionary Fund				800.00
	\$ 1,000.00	\$ 214.12	\$ 785.88	\$ 1,800.00
(f) CONTINGENT FUND				
Transfer from Oper. Cap.	\$ 10,000.00			\$ 10,000.00
Taxes		\$ 884.66		
Salaries—Add. Personnel		2,246.70		
Payroll Tax—Add. Personnel		2.38		
AMA Leadership Meeting		688.93		
Auxiliary Scholarship		250.00		
Dr. Barrow Travel		115.81		
Partitions		4,288.20		
Socio-Economics		10.40		
Employee Ed. Imp.		80.84		
Physician-Lawyer Broch.		199.50		
Geriatric Seminar		224.25	1,008.33	
	\$ 10,000.00	\$ 8,991.67	\$ 1,008.33	\$ 10,000.00
2. JOURNAL				
Printing	\$ 40,000.00	\$ 36,386.64	\$ 3,613.36	\$ 40,500.00
Salaries	10,200.00	10,166.60	33.40	11,800.00
Insurance	905.00	623.75	281.25	750.00
Payroll Tax	750.00	689.03	60.97	850.00
Engraving & Cuts	2,500.00	2,148.26	351.74	2,025.00
Postage & Copyright	1,600.00	1,319.43	280.57	1,700.00
Clipping Service	200.00	141.10	58.90	175.00
Addressograph & Sup.	250.00	33.28	216.72	250.00
Sundry	50.00	45.66	4.34	50.00
TOTAL JOURNAL EXPENSE	\$ 56,455.00	\$ 51,553.75	\$ 4,901.25	\$ 58,100.00

* Indicates Funds available from Committee Contingent Fund.

REFERENCE COMMITTEE RECOMMENDATION

—Your Committee recommends approval of the Budget in toto with commendation, and recommends that Reference Committee F be appointed prior to the meeting of the Finance Committee and that members of the Committee be invited to attend the annual budget planning session. Your Committee also recommends that some continuity be established in naming the members of Reference Committee F.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Finance.

GEORGIA REGIONAL MEDICAL PROGRAM

M. C. ADAIR, M.D., *Coordinator*, and
J. GORDON BARROW, M.D., *Director*

On December 31, 1972, the Georgia Regional Medical Program completed one of its most successful years and was looking forward to an even greater year in 1973 for which it had been approved for funding at a

level of \$3.021 million. Mr. Nixon, however, late in December, 1972 in his Budget Message to Congress suddenly proposed the termination of the Regional Medical Program along with a general reduction in other federally supported health programs. This resulted in the impoundment of \$1.751 million of Georgia funds leaving us with only a six-month award of \$1.281 million with no further project funding due after June 30, 1973. Certain key staff members were to be allowed to continue until early 1974 in order to make final fiscal arrangements, terminal reports, evaluations of the program, etc.

At this point, it appears as though Congress may make a very serious attempt to question this decision by the President and reinstate RMP in spite of the President's recommendation. We will bring the members of the House of Delegates completely up to date at the time of the annual meeting. We trust that we will be able to bring good news.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee receives the report of the Director of the Georgia Regional Medical Program with interest and approval.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Georgia Regional Medical Program.

Election Results

Speaker Rogers then called on Dr. Billy Hardman, chairman of the Teller's Committee, to announce the results of the election for the office of President-Elect. Dr. Hardman announced the election results as follows:

President-Elect—John Rhodes Haverty, M.D., Atlanta

The Speaker then called for unfinished business

and there was none. He then asked for new business and there was none.

Speaker Rogers thanked all members of Reference Committees for their diligent work and thanked all members of the House for their close attention to the work of the House, and likewise extended his thanks to the Headquarters Staff for their assistance in helping with the work of the House. He called for a motion to adjourn the Second Session of the MAG House of Delegates and on motion made and seconded he declared the final session of the House of Delegates adjourned and turned the meeting back to First Vice President Braswell Collins for the continuation of the Second General Business Session of the MAG General Session.

MAG Second General Session (Reconvened)

119th Annual Session of the Medical Association of Georgia
Sunday, May 13, 1973

FIRST VICE PRESIDENT Braswell Collins then reconvened the Second Session of the 119th Annual Session of the Medical Association of Georgia and expressed his appreciation to Dr. Harrison Rogers and Dr. Rhodes Haverty for their efficient handling of the business of the House of Delegates.

He reminded the Delegates that MAG President F. William Dowda, Atlanta had been unable to attend the Annual Session due to the illness of his mother and urged everyone to "drop Bill a note, I know he will be glad to hear from you."

Dr. Collins then called for the drawing of the exhibit attendance prize and asked MAG Managing Editor Kathy Morse to assist in the drawing. He announced the winner who was Dr. Milton I. Johnson of Macon, and presented him with a portable television set as the exhibit attendance prize.

Installation of Officers

Dr. Collins then asked the incoming president, the officers, the AMA delegates and alternates, councilors and vice councilors, to please assemble in front of the Speaker's platform for the administering of the oath of office and the installation of officers as follows:

President—C. Emory Bohler, Brooklet (1974)
President-Elect—J. Rhodes Haverty, Atlanta (1975)
First Vice President—H. Hilt Hammett, LaGrange (1974)
Second Vice President—Luther M. Thomas, Augusta (1974)
Vice Speaker—L. C. Buchanan, Decatur (1974)
First District Councilor—Albert M. Deal, Statesboro (1976)
First District Vice Councilor—Leon E. Curry, Metter (1976)
Second District Councilor—J. Daniel Bateman, Albany (1976)
Second District Vice Councilor—Frank R. Miller, Thomasville (1976)
Third District Councilor—John H. Robinson, Americus (1976)
Third District Vice Councilor—B. Lamar Pilcher, Warner Robins (1976)
Medical Association of Atlanta Councilor—J. Harold Harrison (1976)
Medical Association of Atlanta Vice Councilor—William W. Moore, Jr., Atlanta (1976)
Georgia Medical Society Councilor—L. R. Lanier, Jr., Savannah (1976)
Georgia Medical Society Vice Councilor—Irving Victor, Savannah (1976)
AMA Delegate—J. W. Chambers, LaGrange (1975)
AMA Delegate—John S. Atwater, Atlanta (1975)
AMA Alternate Delegate—F. G. Eldridge, Valdosta (1975)

Incoming President C. E. Bohler leads his fellow new officers as they repeat their oaths: (L-R) Buchanan, Vinton, Haverty, Bohler, Chambers.



AMA Alternate Delegate—Luther M. Vinton, Avondale Estates (1975)

Dr. Collins administered the oath of office to the assembled new officers of MAG and declared each of the officers duly installed. Dr. Collins then turned the gavel of leadership over to incoming President C. Emory Bohler who expressed his appreciation to those present for the honor of being selected President for the 1973-74 year. President Bohler then acknowledged the President's key and the bound volume containing issues of the *Journal of the Medical Association of Georgia* published during Dr. Dowda's term as President, and indicated that these

would be delivered to Dr. Dowda.

President Bohler then announced that the new MAG Council and Executive Committee would hold their organizational meetings immediately and entertained a motion for adjournment sine die of the 119th Annual Session. The House adjourned at 1:15 p.m.

Official Attendance at the 119th Annual Session was:	
612	Members
119	Guest M.D.'s
163	Guests
216	Woman's Auxiliary
182	Exhibitors
1,292	TOTAL REGISTRATION

HIGHLIGHTS OF MAG COUNCIL MEETING

May 9, 1973

Budget: Recommended to House of Delegates approval of 1973-74 Budget of \$473,000 as submitted by Finance Committee.

Certificates of Appreciation: Additional presentations approved: State Representative Harry Dixon; Senator Frank Coggin; AMA Alternate Delegate Henry S. Jennings, M.D.; First District Councilor C. Emory Bohler, M.D.

Osteopath Designation as M.D.: Received report from legal counsel on contents of AMA officers' depositions; and also a report from hearing of suit.

GaMPAC: Heard report on Board of Directors appointments by District: 1) Carson B. Burgstiner, M.D., Savannah; 2) Robert P. Wight, M.D., Tifton; 3) James H. Sullivan, M.D., Columbus; 4) John P. Heard, M.D., Decatur; 5) (Vacant); 6) Ferrol A. Sams, Jr., M.D., Fayetteville; 7) Lee H. Battle, Jr., M.D., Rome; 8) William R. Birdsong, M.D., Macon; 9) Billy S. Hardman, M.D., Gainesville; 10) James K. McDonald, M.D., Augusta.

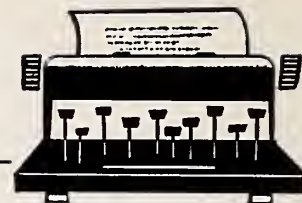
Board of Human Resources: Report presented by Corbett Turner, M.D. Also, James W. Alley, M.D. introduced as new director, Division of Physical Health.

Insurance: New figures and percentage increase on St. Paul liability insurance presented: Class I—\$227 (7.1 per cent); Class II—\$398 (16.7 per cent); Class III—\$862 (8 per cent); Class IV—\$1,077 (15.3 per cent); Class V—\$1,221 (16.6 per cent).

Bylaws: Approved language for submission to House of Delegates on increasing minimum size of newly chartered county medical societies to 15 members.

Disciplinary Board: Heard report from Ad Hoc Committee on meetings with Medical Examiners and agreement to establish investigative committee. Referred agreement document to MAG legal counsel for review.

County Medical Society Executive Secretaries: Approved inviting Executive Secretaries to all meetings of Council in order to keep them better informed on MAG activities.



John Rhodes Haverty MAG President-Elect

THE COMING YEAR will be one of preparation for John Rhodes Haverty, Atlanta, installed as president-elect of the Medical Association of Georgia at the 119th Annual Session in Augusta May 10-13. A pediatrician, Dr. Haverty is dean and professor of the School of Allied Health Sciences of Georgia State University.

The President-Elect was born in Atlanta and received his early training in the capital city, in Greenville, S.C. and in Chattanooga, Tenn. His A.B. degree was earned at Princeton University and his M.D. from the Medical College of Georgia in 1953.

Dr. Haverty served a rotating internship at Jackson Memorial Hospital in Miami, Fla., following which he completed a residency in pediatrics at St. Christopher's Hospital for Children in Philadelphia, Pa. He was chief resident in pediatrics at Grady Memorial Hospital in Atlanta in 1956, and entered private practice in Atlanta the following year.

Dr. Haverty is a Diplomate of the American Board of Pediatrics and Fellow of the American Academy of Pediatrics. He is a member of the Medical Association of Atlanta and for MAG has served as chairman of the Medical Education Committee, vice speaker of the House of Delegates and secretary from 1966 to 1972.

Lending his talents to other organizations, Dr. Haverty is on the medical advisory board of the Planned Parenthood Association, member of the Georgia Science and Technology Commission, director of the Village of St. Joseph, Georgia Association of Children with Learning Disabilities and the Florence Crittenton Home. He has served as consultant to the Georgia State Adoptions Board and the Crippled Children's Service Cardiac Clinic of the Department of Public Health.

A deacon and elder for Trinity Presbyterian Church in Atlanta, Dr. Haverty is also active in the North DeKalb Rotary Club, Piedmont Driving Club and Princeton Club of New York.

Dr. and Mrs. Haverty, the former Lulyanne Seigler of Augusta, have two daughters and one son.

Highlights of the 1973 MAG Annual Session

AUGUSTA WAS THE SITE of the 119th Annual Session of the Medical Association of Georgia. The May 10-13, 1973 meeting drew 1,300 physicians, exhibitors and guests.

Participants this year had ample opportunity to display their athletic prowess in the Medical Mile, tennis and golf tournaments, and their artistic skills in the Art Show.

Many of the specialty societies met during Annual Session, holding both scientific and business meetings. Participants in special programs included: John R. Kernodle, M.D., chairman, AMA Board of Trustees; James W. Turpin, M.D., founder and international director, Project Concern; Raymond Robillard, M.D., president, Federation of Medical Specialists, Canada; and Sidney B. Weinberg, M.D., chief medical examiner of Suffolk County, New York.

Meeting in conjunction with Annual Session was the MAG House of Delegates which considered numerous reports and resolutions, some of which are highlighted below. A full presentation of each report and resolution, subsequent recommendation of the Reference Committee to which it was referred and final action taken by the House of Delegates appears elsewhere in this *Journal*.

Annual Session

The House approved separation of the scientific from the business meeting with the General Session and House of Delegates meeting for two and a half days in May rotating around the state. The Scientific Session may meet in Atlanta or resort areas in or out of the state or country during the autumn.

Maternal and Infant Welfare

The Delegates voted to urge the Governor to extend the food stamp program to all counties in Georgia to improve infant and maternal nutrition. The House, also, approved use of family planning, sex education in the schools and other appropriate means to help reduce incidence of adolescent pregnancy.

Rural Health

Continued approval of the operation and program of establishing health access stations was voted by the House.

Emergency Medical Services

The Delegates voted to direct the MAG Committee on Legislation to work toward amending P.L. 37 to exclude physicians and certified paramedical personnel from the detrimental effects of the Act which may include supercession of the Good Samaritan Law.

PSRO

The House approved MAG's taking a posture of watchful waiting on PSRO development, of working to change the law, of offering constructive input in development of guidelines for PSRO's, and of entering no contract with any government agency without referring the matter back to the House of Delegates.

Peer Review

The Peer Review Committee was instructed to identify educational needs of Georgia's physicians, presenting them to the Education Committee to develop and implement programs designed to alleviate these needs with the approval of the Executive Committee.

EMCRO

The House retained for itself the responsibility for reviewing the EMCRO program before it becomes operational. A financial report and a copy of the grant renewal will be sent to all delegates as directed by the House.

Georgia Medical Care Foundation

The House recommended that the Foundation Board create a separate committee for claims review and that the Foundation utilize the MAG Peer Review Committee and Specialty Societies for utilization and quality review.

Committee on Organization and Functions

The Delegates approved creation of an ad hoc committee to study MAG's structure, organization and functions. Specific charges to this committee include the study of: (1) encouraging small county medical societies to merge; (2) dividing the state into cohesive medical trade areas; (3) restricting the growth of the size of Council; and, (4) defining the respective responsibilities and roles of Council and Executive Committee.

Newborn Insurance

A resolution to activate an informational campaign to apprise the public of the need for all Georgia insurance companies offering defendant coverage to include newborn coverage from birth was endorsed by the House; additionally, the county medical societies are to be requested to aid in this effort.

Osteopaths

The Delegates agreed to defer action to a more appropriate time on osteopathic membership in MAG and to maintain improved communications through MAG's liaison committee.

Quackery

The House of Delegates commended the Committee on Quackery and encouraged its continued efforts to combat the spread of chiropractic and to support legislation that would curb chiropractic activities in Georgia.

MAG Membership

The Delegates approved several changes in the MAG bylaws: (1) deletion of the citizenship requirement for membership; (2) active membership status for interns and residents; (3) revocation of non dues paying status for some service members.

Continuing Medical Education

The Delegates authorized encouraging all hospital medical staffs to establish programs of continuing education for their hospital under the direction of a medical director or a continuing medical education committee of the hospital staff. Such programs would be eligible for accreditation by the MAG's accrediting agency when it has been approved by AMA.

Joint Practice Committee

Approval by the House was voted for the establishment of joint practice committees between physician and nurse organizations at the county and district levels to establish the needs and the extent of the role of the nurse in the particular area.

Anti-substitution Law

The House resolved to oppose any change in Georgia's Anti-substitution law

(prescription drugs) that would permit substituting a therapy not specifically approved by the physician prescribing the therapy.

Medical Disciplinary Law

The Delegates approved creation of a Medical Investigative-Disciplinary Committee to assist the Composite State Board of Medical Examiners in performance of its duty to enforce the Medical Practice Act by investigating physicians when deemed necessary by the Composite Board or when requested by the MAG Executive Committee.

Interspecialty Council

The House reviewed the language for amending the MAG Constitution and By-laws necessary to create an Interspecialty Council and authorizing specialty society representation in the House of Delegates. Pursuant to these amendments to be voted on by the 1974 House of Delegates, the Chairman of the Interspecialty Council would serve on the MAG Council.

Access to Health Care

The President of MAG was directed by the House of Delegates to appoint an ad hoc committee on Access to Health Care to develop the methodology for identifying areas of Georgia where access is a problem and devising a means for implementation of any solutions.

Awards

R. D. Walter, M.D., Calhoun, was recognized as the Family Physician of the Year; the Hardman Cup Certificate was awarded to A. Hamblin Letton, M.D., Atlanta; Luther H. Wolff, M.D., Columbus, was presented the Distinguished Service Award; the Civic Endeavor Award was presented to Luther G. Fortson, M.D., Marietta.

Scientific Awards went to: First, C. Martin Rhodes, M.D., and W. D. Jennings, M.D., Augusta, "Localized Excision in Dupuytren's Contracture"; Second, Thomas J. Yeh, M.D., James L. Alexander, M.D., and C. Walker Beeson, III, M.D., Savannah, "Surgery for Coronary Heart Disease"; Third, W. D. Logan, M.D. and Associates, "Surgery for Impending Myocardial Infarction."

GaMPAC Awards were presented to the following societies: The Ogeechee River Medical Society for the county medical society with the highest percentage of GaMPAC membership; The Fourth District Medical Society for the district medical society with highest percentage of GaMPAC membership; The Medical Association of Atlanta for the county society which contributed the most money to GaMPAC.

Officers

C. Emory Bohler, M.D., Brooklet, president, led the MAG officers who were installed. J. Rhodes Haverty, M.D., president-elect, Atlanta, headed the list of officers elected by the House of Delegates. Additional MAG officers elected and/or installed include: F. William Dowda, M.D., Atlanta, immediate past president; H. Hilt Hammett, M.D., LaGrange, first vice-president; Luther M. Thomas, Jr., M.D., Augusta, second vice-president; L. C. Buchanan, M.D., Decatur, vice-speaker; J. W. Chambers, M.D., LaGrange and John S. Atwater, M.D., Atlanta, AMA delegates; F. G. Eldridge, M.D., Valdosta, Luther M. Vinton, Jr., M.D., Avondale Estates, AMA alternate delegates.

Future Meeting Sites

Future meeting sites for Annual Session were announced as follows: 1974, Savannah; 1975, Atlanta; 1976, Jekyll Island; 1977, Macon; 1978, Augusta; 1979, Savannah; 1980, Atlanta.

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References: 1. Olsen, J.R.: *Journal-Lancet* 85:287 (July) 1965. 2. Giorlando, S.W.: *Ob/Gyn Dig.* 13:32 (Sept.) 1971. 3. Decker, A.: *Case Reports on File, Medical Department Julius Schmid*. 4. Giorlando, S.W., Torres, J.F., and Muscillo, G.: *Am. J. Obst. & Gynec.* 90: 370 (Oct. 1) 1964. 5. Lechevalier, H.: *Antibiotics Annual 1959-1960*. New York, Antibiotica Inc., 1960. pp. 614-618. 6. Friedel, H.J.: *Maryland M.J.*, 15:36 (Feb.) 1966.



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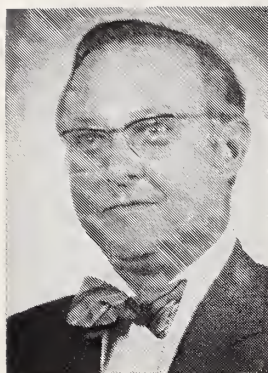
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Just Beginning

THIS IS BEING PREPARED before the Annual Session in Augusta. I am aware there will be controversy concerning Professional Standards Review Organization, but I feel certain the final decision will be the right decision and will be arrived at after careful, deliberate and probably prolonged discussion.

When a physician who has in the past practiced medicine according to the dictates of his own conscience suddenly is confronted with the possibility that a peer review committee will be legally entitled to actually investigate or review his office records, he becomes alarmed and perhaps justifiably rebellious. We have become accustomed to review of our hospital and nursing home records even though many of us are downright resentful and in rare instances even uncooperative; but the PSRO law has been enacted and will be implemented by the Secretary of HEW with or without our cooperation.

As I see it, the problem resolves itself to the simple question; who will do review? Our true peers or someone appointed by a bureaucrat?

In either event, there will be many problems and I submit that the problems confronting us as physicians, engaged in the private practice of medicine, have only begun; most certainly the next step by the Congress will be National Health Insurance and then there will be the necessity of proving one's competence by postgraduate education or certification.

With tongue-in-cheek, I contend that review of physicians' office records will be a dismal failure; who in Hell could read them other than the guy what wrote 'em?!

A handwritten signature in cursive script, reading "Charles E. Bohler, M.D.".

Charles Emory Bohler, M.D.
President, Medical Association of Georgia



USE OF LOW DOSE HEPARIN IN PREVENTING VENOUS THROMBOSIS

JEROME B. BLUMENTHAL, M.D., *Marietta**

THE PHYSICAL DIAGNOSIS of thrombosis of the deep veins of the leg is totally inadequate, and useless as an early indicator of involvement.

The technique of external counting, after incorporation of administered ¹²⁵I-labelled fibrinogen into developing thrombi, has provided a means of diagnosing deep vein thrombosis. In addition it has proved effective for following a given thrombus for evidence of propagation or lysis. Good correlation with phlebography has been determined.

High Risk Settings

Such techniques have been applied as a screening tool in settings known to predispose to pulmonary emboli in efforts to predict susceptible subjects and offer opportunities for early treatment. Up to 35 per cent of postoperative patients, over the age of 40, have had evidence of deep vein thrombosis, confirmed by phlebography, despite the lack of any clinical signs.

Likewise, patients with myocardial infarction are usually relatively immobilized as a routine part of their management, which may be expected to predispose to similar involvement. An incidence of 25-35 per cent has been noted. Surprisingly, patients treated essentially the same, but, who in the final analysis, did not suffer myocardial infarction, have an incidence of only about 10 per cent. Most of the involvement is in the first few days.

The association between leg vein thrombosis and pulmonary embolism is well known. Also most agree that techniques for diagnosis of pulmonary embolism are insensitive and that certainly the condition is not recognized nearly as frequently as it occurs as determined by routine autopsy studies. It seems therefore highly desirable to develop a safe, effective protocol for prevention of deep vein thrombosis in high risk settings, such as mentioned above.

Effects of Drugs

Heparin has numerous effects on the clotting mechanism, affecting thrombin function and platelet factors, platelet release of ADP, platelet aggregation, as well as others.

Aspirin has been shown to inhibit platelet aggregation induced by collagen fibers and has been investigated as an antithrombotic agent with conflicting results.

Studies in varying settings using low dose heparin recently have tended to yield favorable results.

Most uniform are results in elective surgical patients when heparin in doses

** Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*

varying from 2,500 units four times a day to 5,000 units three times daily, subcutaneously, begun before surgery and continued for a variable number of days after, is highly effective in preventing deep leg vein thrombosis by 125 I-labelled fibrinogen counting techniques.

It is suggested that heparin need be continued only for about three days post-operative to achieve the same result as longer therapy. The incidence of complications at this dose is negligible.

After Immobility Begins

Results seem to be less convincing when heparin is begun hours to days after the onset of immobility as with hip fracture. It is possible, however, that heparin may still prevent pulmonary embolism by preventing proximal propagation of the clot to sites from which emboli are more likely to occur, so that in these patients a positive scan may not indicate as great a risk for significant pulmonary embolism.

Possible prophylaxis of pulmonary embolism is of extreme interest to the cardiologist, of course. Data on patients with acute myocardial infarction are conflicting. A distinctly negative study is open to criticism because of a twice daily dosage schedule. Other studies are more favorable with up to 50 per cent reduction in the incidence of deep vein thrombosis on low dose heparin.

Patients with congestive heart failure, chronically, hospitalized for treatment, have shown a marked decreased incidence of venous thrombi on dosage regimens of 5,000 units three times daily, as compared to placebo injected controls.

This dose does prolong the partial thromboplastin time of many patients. And in a group of surgical patients did slightly increase transfusion requirements, but was not associated with significant hemorrhagic complications.

In summary, deep leg vein thrombosis, and hence pulmonary emboli, may be prevented, or limited in extent, by prophylactic low dose, subcutaneous, heparin in patients predisposed to these complications.

The dose need not be high as that which significantly prolongs the clotting time, or is associated with hemorrhagic complications. This, coupled with its rapid onset of action, may make it preferable to oral agents.

50 Plaza Way 30060

HIGHLIGHTS OF ORGANIZATIONAL MEETING OF MAG COUNCIL

May 13, 1973

Elections: Chairman, David A. Wells, M.D., Dalton; Vice Chairman, L. C. Buchanan, M.D., Decatur.

Appointments: Edgar Woody, Jr., M.D., Atlanta, Editor, *Journal of MAG*; F. G. Eldridge, M.D., Valdosta, Chairman, Finance Committee; Fleming L. Jolley, M.D., Atlanta and J. T. Christmas, M.D., Vienna—members.

Next Meeting: Cloister, Sea Island, September 22-23, 1973.

HIGHLIGHTS OF ORGANIZATIONAL MEETING OF MAG EXECUTIVE COMMITTEE OF COUNCIL

May 13, 1973

Executive Director: Selected James M. Moffett as MAG Executive Director for 1973-74.



THE NEW GEORGIA ABORTION LAW

J. WINSTON HUFF, *Atlanta**

AS HAS BEEN WIDELY PUBLICIZED, in January of this year the Supreme Court of the United States struck down much of the Georgia law governing abortions. The Court's decision in the Georgia case¹ and in a companion case involving the Texas abortion law² placed severe limits on the right of a state to regulate abortions.

After some travail, the recent session of the General Assembly of Georgia enacted a new abortion law which was approved by Governor Carter and became effective on April 13, 1973. This new statute appears to comport with the Supreme Court's mandate.

Primary Points

Under this new Act, unauthorized abortion is still a criminal offense. And, although there are no longer as many restrictions and formalities, some do indeed remain. Therefore, it is important for Georgia physicians to know when and under what circumstances abortions may now be legally and properly performed in this state. The salient features of the new law are these:

Who: All abortions must be performed by a physician duly licensed to practice medicine in this state.

Standard of Decision: (1) In all cases the attending physician must determine that, "based on his best clinical judgment," the abortion is "necessary." (2) During the first two trimesters, the sole standard for deciding whether the abortion should be performed is the attending physician's determination that the abortion is "necessary" based on his best clinical judgment. The new law gives no definition of what is or is not "necessary." (3) After the second trimester, the attending physician *plus two consulting physicians* must certify that the abortion is necessary in their best clinical judgment *to preserve the life or health of the mother*. If an abortion is performed, and if the product of such abortion is capable of meaningful or sustained life, medical aid then available must be rendered.

Where: (1) During the first trimester, there are no requirements as to the place of the abortion nor the conditions under which the procedure will be performed. During this time, these considerations are left to the best clinical judgment of the physician. (2) After the first trimester, the abortion must be performed in a licensed hospital or health facility licensed as an abortion facility by the Georgia

*Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

Department of Human Resources. (The Georgia Health Code was also amended to give the Department of Human Resources power to license and regulate abortion facilities.)

Reports: Within 10 days after the abortion, the performing physician must file with the Commissioner of Human Resources a Certificate of Abortion containing such data as is determined by the Department of Human Resources consistent with preserving the privacy of the woman. Hospital or other licensed health facility records must be available to the District Attorney of the judicial circuit in which the hospital or health facility is located.

Right to Refuse: As was the case with the old law, the new law states that it is not to be taken as requiring a hospital or other medical facility or physician to admit any patient for the purpose of performing an abortion. Further, any person who shall state in writing an objection to any abortion or all abortions on moral or religious grounds shall not be required to participate in procedures which will result in an abortion. The refusal of a person to participate in an abortion procedure shall not form the basis of any claim for damages, or for any disciplinary or recriminatory action against such person.

Although many of the prior restrictions have been removed, a physician will be expected to exercise careful judgment concerning abortions just as he must do in any other situation. For example, during the first trimester there are no statutory requirements as to the place of the abortion procedure, just as there are no statutory requirements for most surgical procedures. However, the facility would have to be clinically adequate, or the physician might be held liable in negligence.

Right to Refuse

The physician's rights and responsibilities appear to be pretty clearly defined by the new law. However, a quite recent decision of the United States Court of Appeals for the First Circuit³ brings into question the provision of the law relating to the right to refuse abortions. As stated above, the Supreme Court let stand that part of the old Georgia law which purportedly permits hospitals, medical facilities and physicians to refuse to admit patients for the purpose of performing abortions. However, this recent case, decided March 22, 1973, holds that a municipal hospital's absolute refusal to allow its facilities to be used in connection with consensual sterilization constitutes a denial of equal protection in violation of the Fourteenth Amendment to the United States Constitution.

The court here used the same rationale as was used by the Supreme Court in the Texas and Georgia abortion cases, saying that the decision to terminate future pregnancy would seem to embrace all the factors that the Supreme Court considered important in the termination of an existing pregnancy. This court held that a complete ban on sterilization procedures relating to such fundamental interests is far too broad when other comparable surgical procedures are routinely performed. Here the court relied on a prior U. S. Supreme Court decision⁴ which held that once a state has undertaken to provide general short-term hospital care, it may not constitutionally draw the line at medically indistinguishable surgical procedures that impinge on fundamental rights. At this point, it would not appear that this most recent decision would require any private physician to perform an abortion. It may mean that, despite the provisions of the Georgia law, a public hospital will not be able arbitrarily to refuse its facilities to abortion patients.

Finally, there is the further question of the in-hospital regulation of abortions. While there are no cases giving a clear indication as yet, it would appear that reasonable hospital rules regulating the qualifications of staff physicians who may perform abortions and otherwise prescribing the clinical conditions under which such procedures must be performed would be held valid. Such rules, however,

obstetrics; **Cosmo L. Haun** to associate professor of radiology; **William C. McGarity** to professor of surgery; **Asa G. Yancy** to associate professor of surgery, retaining appointments of assistant professor of preventive medicine and community health and associate dean of the School of Medicine.

Several Atlantans have been honored by the American College of Physicians. Inducted as Fellows during the April annual meeting were **Arnoldo Fiedotin**, **John M. McCoy** and **Donald O. Nutter**.

Sixth District

H. Calvin Jackson, Manchester physician and civic leader, has been selected to appear in the 1973 edition of *Who's Who in Georgia*. Dr. Jackson has practiced medicine in that city since 1948.

Tenth District

Robert B. Greenblatt, professor of endocrinology at the Medical College of Georgia, has been chosen as president-elect of the 8,000 member American Geriatrics Society.

R. Louie Smith, Augusta, has been elected to membership in the American College of Physicians.

DEATHS

Robert Carter Davis, Sr.

Atlanta physician, Robert Carter Davis, Sr., died May 6 of congestive heart failure at the age of 62.

The former president of the Medical Association of Atlanta was born in Georgia's capital city, was graduated from Emory University School of Medicine, and later studied internal medicine at the University of Michigan and Harvard College. During World War II, he served as a Navy Medical Corpsman. He was a member of the Capital City Club.

Survivors include his widow, Mrs. Hilda Brown Davis; daughters, Mrs. Joseph McGee of Atlanta and Mrs. Walter Chamberlain of New Orleans, La.; sons, Dr. Robert Carter Davis, Jr., Theodore Davis and Render Davis of Atlanta and Christopher Davis of New York, N.Y.; sisters, Mrs. Earl McMillen, Mrs. John Varner and Mrs. Sarah McFadden of Atlanta, Mrs. Storm Trosdal, Jr. of Savannah and Mrs. Fred Marks of Sarasota, Fla.

George Rodolphus Dillinger

A former president of the Medical Association of Georgia, George Rodolphus Dillinger, 70, died April 15 following a long illness.

Dr. Dillinger received his B.A. and medical degrees from the University of Indiana, then came to Thomasville in the years of World War II as an Army doctor associated with Finney General Hospital. He established his private practice in Thomasville following the war, and retired in 1965 to join the staff of the Veterans Administration Hospital in Dublin.

Having served as a delegate to the American Medical Association both from Indiana and Georgia, Dr. Dillinger's other activities included memberships in the Elks, Shriners and Kiwanis Club. He was Episcopalian.

Survivors include his widow; three daughters, Mrs. W. L. Huggins of Gautier, Miss., Mrs. D. L. Elgin of

Los Angeles, Calif. and Miss Jeannie Marie Dillinger of Thomasville; sons, David R. Dillinger of Augusta, Charles R. Dillinger of Tallahassee, Fla. and George J. Dillinger of Thomasville; sisters, Miss Amy Irene Dillinger of Thomasville and Mrs. Don A. Mason of Dallas, Texas; several grandchildren.

Ira Goldberg

Augusta physician Ira Goldberg died April 29 in a boating accident in which he was electrocuted.

A graduate of Vanderbilt University and the University of Georgia School of Medicine, Dr. Goldberg established a private practice in obstetrics and gynecology in Augusta in 1953. He served as clinical instructor of OB-GYN at the Medical College of Georgia and chief of staff at St. Joseph Hospital.

He was a fellow in the American College of Obstetricians and Gynecologists, American College of Surgeons and the South Atlanta Association of Obstetricians and Gynecologists. He formerly served as president of the Augusta Federation of Jewish Charities, the Jewish Community Center and Adas Yeshurun Synagogue.

Survivors include his widow, Mrs. Paulette Goldberg; four daughters, Kathy, Vicky, Linda and Wendy Goldberg; parents, Mr. and Mrs. Frank Goldberg; one sister, Mrs. Alan Silver, all of Augusta.

Alpheus Maynard Phillips, Sr.

Alpheus Maynard Phillips, Sr., 69, of Macon, former president of the Medical Association of Georgia, died April 9.

Dr. Phillips had served as a member of the State Board of Health, past president of the Bibb County Medical Society, member of the American College of Surgeons and fellow of the Southeastern Surgical Congress. He was active in the Macon Civitan Club, former vice president and medical director of Bankers Health and Life Insurance Company and former trustee of Georgia Industrial Home and the United Givers Fund. Dr. Phillips was past master of the Macon Masonic Lodge No. 5, a 33rd Degree Mason and past potentate of Al Sihah Temple.

The Chipley native completed undergraduate work at Mercer University and received his M.D. degree from the Medical College of Georgia. He had lived in Macon since 1928.

Dr. Phillips' widow, the former Julia Green of Macon, survives him. Other survivors include two sons, Dr. A. M. Phillips, Jr. and Robert Phillips of Macon.

Collis Nelson Tomblin, Sr.

Columbus physician Collis Nelson Tomblin, Sr., died May 13 at his residence. He was 43 years old.

Dr. Tomblin's many professional affiliations included membership in Muscogee County Medical Society, American Medical Association and the American Board of Obstetrics and Gynecology for which he was a diplomate. Dr. Tomblin was a member of Waldrop Memorial Baptist Church.

His survivors include his widow, Mrs. Glynn Wood Tomblin of Columbus; daughter, Miss Susan Lynn Tomblin of Columbus; sons, Collis Nelson Tomblin, Jr. at the University of Georgia in Athens and Alan Reid Tomblin of Columbus; brother, Maj. E. Derrill Tomblin of Laurel, Miss.; grandmother, Mrs. Annie B. Gibson of Columbus.

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Contraindications: History of hypersensitivity to thiabendazole.

Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

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patients should be carefully monitored.

Adverse Reactions: Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions

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Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	1/2
50	0.5	1
75	0.75	1 1/2
100	1.0	2
125	1.25	2 1/2
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days. This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

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Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines. To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage. In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses. Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days. **SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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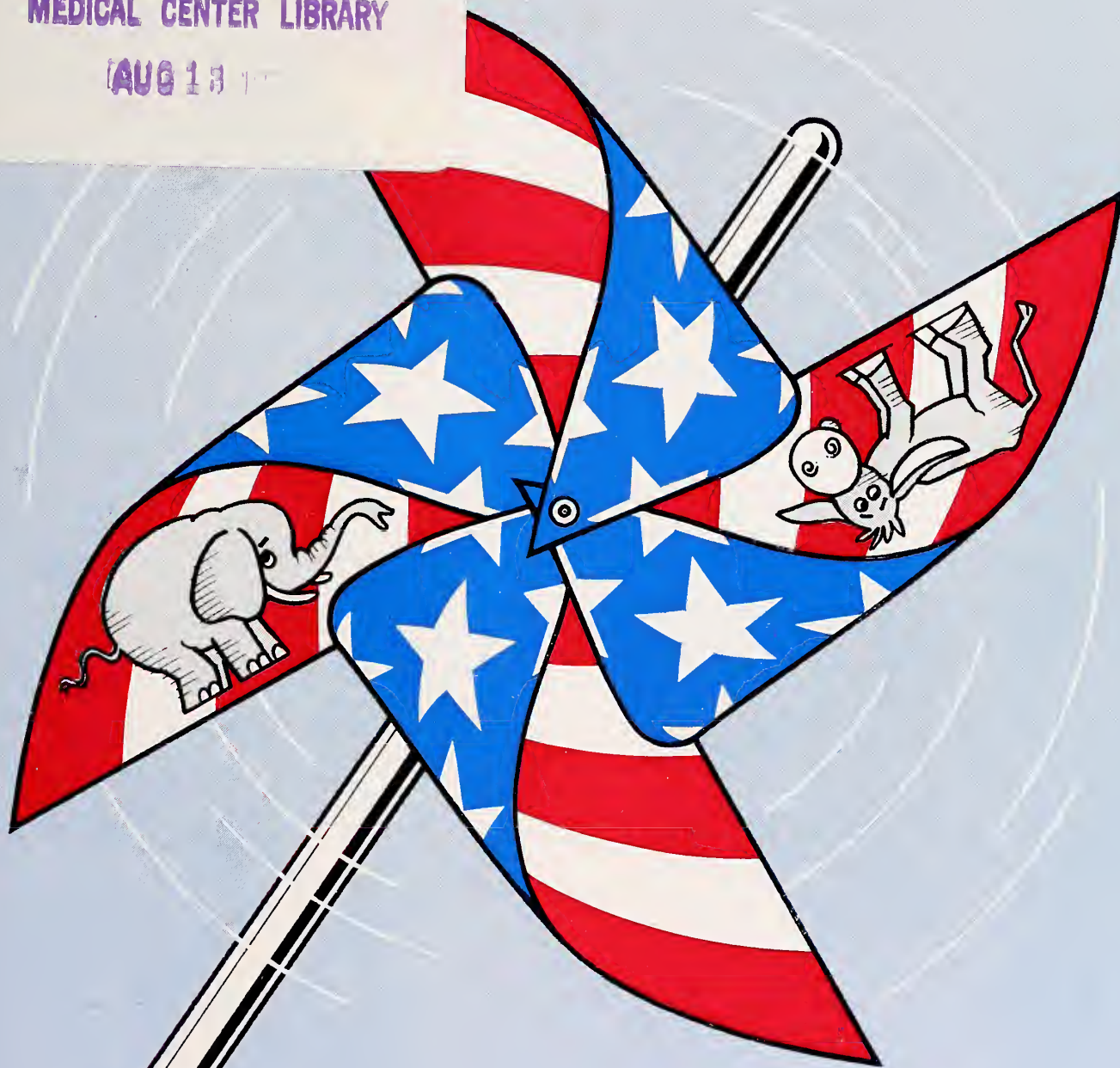
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HAPPY POLITICS

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Everybody experiences psychic tension.



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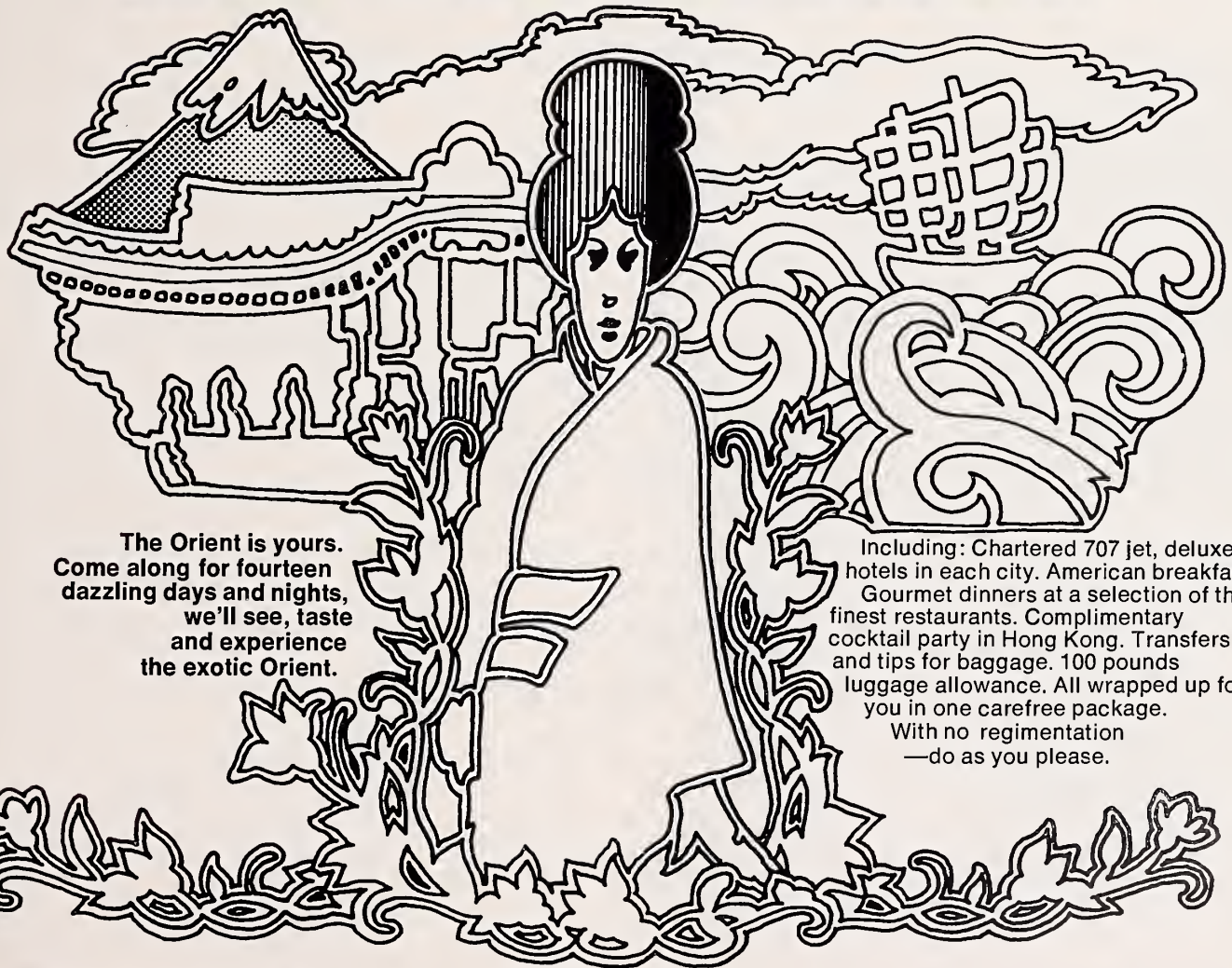


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Cover

July's fanciful pinwheel by Atlanta artist Bob Hamill complements the tone of the article inside by authors Maughon and Raines which gives a light-hearted look at political involvement.

*Photocoagulation with the Argon laser
now offers new hope to the patient
with advancing retinopathy.*

The Modern Treatment of Diabetic Retinopathy

WILLIAM H. JARRETT, M.D. and WILLIAM S. HAGLER, M.D., Atlanta

DIABETES MELLITUS, with its attendant complication of diabetic retinopathy, is rapidly becoming the leading cause of blindness in the United States today. There is a direct correlation between the duration of diabetes and the eventual development of diabetic retinopathy. Consequently, as modern medical advances prolong the life span of the individual diabetic, he stands a greater chance of developing the ocular complications of diabetes. Statistics concerning this disease and its ocular complications are compiled in Table 1. These would indicate that approximately 100,000 Georgians have diabetes, and approximately 38 per cent of these have or will develop diabetic retinopathy.

Despite widespread interest and research activities, the exact pathogenesis of diabetic retinopathy is unknown. A widespread microangiopathy is present, however, characterized by changes in the mural cells of the capillary wall. As these changes progress, a sequence of pathologic events occurs, characterized by localized ischemia, exudation of intraretinal

edema fluid and lipid, formation of microaneurysms, development of intraretinal hemorrhage, and, finally, development of new-formed blood vessels from the surface of the retina and optic nerve head. These new-formed vessels frequently bleed into the vitreous cavity, resulting in marked and sometimes irreversible loss of vision.

The earliest changes of diabetic retinopathy, observed clinically, are the development of small hemorrhages, microaneurysms, and exudates. These are usually asymptomatic, do not cause visual disturbance, are transitory in nature, and do not require treatment. In some fortunate patients, the retinopathy does not progress beyond this point, and such individuals are not threatened with blindness.

Causes of Visual Loss

From the ophthalmologist's standpoint, there are two major causes of visual loss from diabetic retinopathy. These are:

1. Development of macular edema;
2. The development of retinitis proliferans, with subsequent recurrent vitreous hemorrhage and traction retinal detachment.

Macular edema occurs as a result of hemodynamic changes in the macular region, resulting in the accumulation of serum and lipid material into the retinal tissue itself (Figure 1). Numerically, this is the most common cause of legal blindness (vision less than 20/200) arising from diabetes. It does not cause the dramatic and profound visual loss that retinitis proliferans and vitreous hemorrhage causes.

**TABLE 1
DIABETES AND DIABETIC RETINOPATHY:
STATISTICS**

1. 4,000,000 Americans have diabetes
38% of diabetics develop retinopathy
2. Duration versus retinopathy
After 16 years, 64% have diabetic retinopathy
After 20 years, 93% have diabetic retinopathy
3. Diabetes is now the leading cause of blindness in the United States

RETINOPATHY / Jarrett, Hagler

but the ocular morbidity from macular edema in diabetes is of great importance.¹

Retinitis proliferans, with its frequent attendant complications of massive vitreous hemorrhage and traction retinal detachment, is responsible for the most severe degree of visual impairment seen in diabetes, often reducing vision to the level of hand motions or even total loss of light perception. In this form of retinopathy, newly formed blood vessels arise from the optic disc and surface of the retina. These new vessels grow, in three dimensional fashion, into the vitreous cavity (Figure 2). These vessels are fragile, and hemorrhage from them is quite common. In addition, fibrous tissue forms along these new-formed vessels, and on the surface of the retina as well. This fibrous tissue can contract and cause either localized or extensive retinal detachment, which is frequently not amenable to surgical correction.

Best Treatment: Prevention

The best treatment of diabetic retinopathy is to prevent its occurrence. Unfortunately, even the most meticulously controlled diabetic is likely to develop retinopathy as he lives longer with this disease. By the time diabetes has been present for 20 years, the chances are overwhelming that some form of retinopathy will be present (see Table 1). Paradoxically, the ophthalmologist will occasionally encounter a patient with far advanced retinopathy who is not even known to have diabetes until the ophthalmolo-

gist suggests the correct diagnosis.

A wide variety of medical regimens have been suggested for controlling diabetic retinopathy. These include rigid control of the diabetes by diet and insulin, strict attention to blood and urine sugar levels, lowering the level of triglycerides in the blood, and use of drugs such as Deca-Dorabolin. The effect of such measures on the clinical course of diabetic retinopathy as regards vision is debatable.

The two major therapeutic modalities popularized within the past decade have been: 1. Pituitary ablation and 2. Photocoagulation. Pituitary ablation, primarily acting by lowering the level of growth hormone in the circulating blood, unquestionably can retard, arrest, or even reverse the progression of proliferative diabetic retinopathy.^{2,3} Pituitary ablation therapy enjoyed a widespread popularity in the early 1960's, but in recent years has been supplanted by photocoagulation as the preferred method of treatment. Nonetheless, in certain selected instances, pituitary ablation can be a most useful therapeutic adjunct.

Photocoagulation

The introduction of photocoagulation by Meyer-Schwickerath in 1947 offered another therapeutic approach to the treatment of diabetic retinopathy, and the recent development of Argon laser photocoagulation has further extended our therapeutic horizons. The earliest commercial photocoagulators utilized a Xenon arc lamp as its source of light energy, producing a beam of high intensity light energy. The emitted spectrum ranges from the infrared



FIGURE 1

Advanced case of exudative diabetic retinopathy, with extensive macular edema, numerous hemorrhages, and lipid deposits at the posterior pole. Vision is reduced to 20/200.

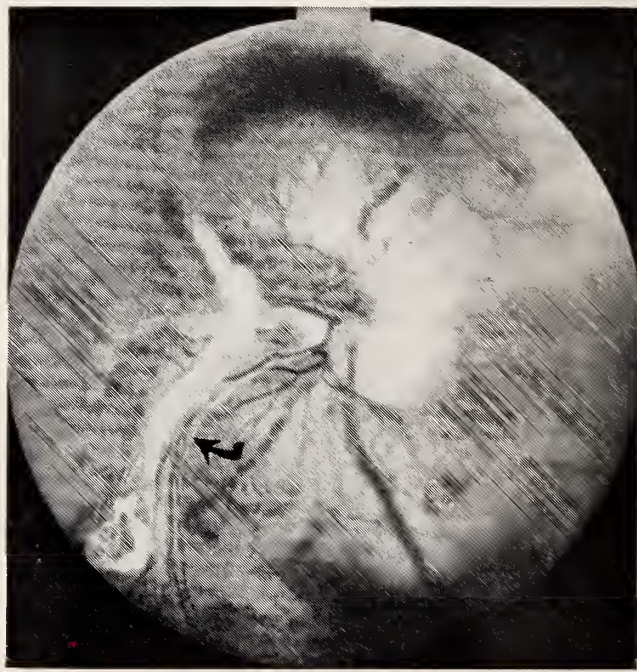


FIGURE 2

Proliferative diabetic retinopathy; new-formed blood vessels extend forward into the vitreous cavity from the surface of the optic disc and retina (arrow), causing massive vitreous hemorrhage.

to ultraviolet, with wavelengths varying from 3,500 to 15,000 angstrom units. The Argon laser, on the other hand, produces a columnated blue-green light with the specific wavelengths of 4,880 and 5,145 angstroms predominating. Hemoglobin selectively absorbs light at these wavelengths, thus making the Argon laser an excellent instrument for the destruction of abnormal blood vessels in the eye. The advantages of the Argon laser are listed in Table 2.

TABLE 2	
ADVANTAGES OF ARGON LASER PHOTOCOAGULATION	
1. Specific absorption by hemoglobin (4880, 5145 Å)	
2. Less energy required	
3. Wide range of spot size, 50-1000 microns	
4. Precision delivery, using slip lamp system	
5. Allow treatment of disc vessels and intravitreal neovascularization	

In photocoagulation treatment, the ophthalmologist attempts to obliterate the retinal and intravitreal neovascularization by the application of light energy, thereby reducing the threat of massive recurrent intraocular hemorrhage and traction retinal detachment. Quite obviously, photocoagulation does not attack the disease at its source, i.e., the underlying metabolic and vascular changes responsible for the development of the new blood vessels in the first place. Thus, photocoagulation treatment can be compared to "weeding a garden." Unfortunately, the "weeds"—the new vessels—can grow back again and destroy the eye by hemorrhage. The therapeutic objective of photocoagulation in diabetic retinopathy is to "gain time" for the patient—to prolong the life span of useful vision in that individual.

A number of authors have reported cautious optimism in the photocoagulation therapy of diabetic retinopathy, utilizing the Xenon instrument and the Argon laser.⁴⁻⁹ Others,¹⁰ however, have cautioned, and correctly so, that the method has not been unequivocally proven and must continue to be investigated and evaluated with controlled studies before the final answer is known.

Criteria for Treatment

Because of the dismal visual prognosis in the advanced case of diabetic retinopathy and because of the encouraging results obtained by others with the Argon laser, we are now treating selected cases of diabetic retinopathy using this modality. In selecting patients for treatment, we do NOT feel that the "background" retinopathy of microaneurysms, retinal hemorrhage, and exudates should be treated. Many of these patients are asymptomatic and will remain so and retain normal vision. However, some of them will show a progressive deterioration of the

microcirculation in the macular region and go on to accumulate intraretinal edema fluid and lipid deposits in the macula.

We have recommended treatment if the visual acuity falls to the 20/60 or 20/70 level or is progressively deteriorating or if serial fundus photographs indicate an accumulation of lipids in the macular region. In such cases, vision can usually be stabilized by treating with the Argon laser (Figure 3). Treatment consists of treating the areas of microangiopathy near the macula with 50 to 100 micron spots of Argon laser light energy.

Patients with proliferative diabetic retinopathy present a much more complex and difficult therapeutic problem. The dismal visual prognosis in such cases should be reemphasized; 30 per cent of patients with peripheral neovascularization will become blind in two years; if new vessels are present on the disc, 60 per cent will lose sight within two years. Such patients may have normal visual acuity initially, but the threat of sudden massive vitreous hemorrhage with total or near total blindness hangs over their head like a sword of Damocles.

We feel that such patients are candidates for photocoagulation, and it is our feeling that we can help the majority of these patients by obliterating the areas of neovascularization on the disc or in the retinal periphery. However, there are certain inherent risks in treating such patients with the Argon laser. The most common complication is intraocular hemorrhage, which occurs in some 5 to 10 per cent of



FIGURE 3

Same eye as Figure 1 following treatment of macular edema with the Argon laser. A fluorescein angiogram (not shown) identifies the "leaking areas," and these have been treated with the Argon laser (arrow) in an attempt to obliterate the areas causing leakage of edema fluid into the retina.



FIGURE 4A

Severe disc neo-vascularization in a one-eyed diabetic patient; the fellow eye had been lost from massive vitreous hemorrhage. Note the huge complex frond of neo-vascularization arising from the optic disc (arrows). This extends into the vitreous cavity, in three dimensional fashion, and its presence represents a severe threat of vitreous hemorrhage.



FIGURE 4B

Same eye, three weeks after ablation therapy using Argon laser. Note disappearance of neo-vascular tissue from the disc; the disc is pale, and the retinal arterioles are narrowed. Visual acuity remains 20/20, and the patient is unaware of any loss of peripheral visual field.

cases treated. The pros and cons are frankly and openly discussed with the patient, and the final decision of course rests with him as to whether or not treatment should be performed.

At the present time, we are finding that peripheral retinal ablation is of value in treating proliferative diabetic retinopathy. Treatment consists of placing 400 to 700 spots, 1,000 micron in size around the periphery of the retina, sparing the disc, macula, and temporal vascular arcade. Two to four weeks after such treatment, the previously dilated and engorged retinal veins return to a normal caliber, the retinal arteries become narrow, and the optic disc becomes pale, and both peripheral and disc neovascularization either disappears or becomes much less marked (Figure 4). These reduced areas of neovascularization are then easier to treat focally, with less risk of hemorrhage. Surprisingly enough, the patients do not exhibit defects in the visual field and do not complain of diminished vision. However, the light sense is definitely diminished and some patients become aware of iatrogenic night blindness after this form of treatment.

In summary, photocoagulation with the Argon laser now offers some hope to the patient with advancing diabetic retinopathy. It is the responsibility of the internist and family physician caring for such patients to obtain ophthalmological advice and guidance when diabetic retinopathy becomes apparent, because some of these patients can be helped with early treatment.

575 West Peachtree Street, N.W. 30308

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This Muscogee group discovered it was a pleasure getting to know its legislators as individuals.

Happy Politics

SHARON MAUGHON and JACK RAINES, M.D., Columbus*

THE SMOKE-FILLED ROOM, well-heeled fat cats and the traditional power brokers are images which have for far too long discouraged effective political action by the average interested citizen. Those serious students and practitioners of the political art may consider us naive beyond belief. Nonetheless, two rank neophytes thoroughly enjoyed activities on behalf of health legislation during the past legislative session. Furthermore, our legislators emerged from the distant realm of newspaper copy and one-dimensional television images to become for us individuals whose aims, aspirations and efforts were fundamentally directed toward our common goal of what is best for the entire community. It is not our purpose to instruct or advise. We do want to share with you a joint effort undertaken by the Muscogee County Medical Auxiliary and the Muscogee County Medical Society which was a very delightful experience and which in retrospect appears to have been worthwhile. From our viewpoint a combination that occurs all too seldom.

Buddy System

Let us turn first to the more sober, mundane, practical organizational effort. The Legislative Committee of the Muscogee County Medical Society elected to pursue a "Buddy System." Each member of the legislative committee was assigned a particular legislator. These pairings, wherever possible, were based on prior amicable relationships or in some instances long-standing friendships. Other pairings, lacking any previous base, were made on the basis of similar age and interests insofar as this could be determined from common knowledge. In either case, each committee member was asked to offer himself to the legislator as a resource person. In addition, the legislator was specifically invited to re-

quest any other member of the medical society that he would prefer to act as his resource person. The medical individual was presented as a person who would communicate to the best of his ability factual clarification of the issues involved in any piece of medical legislation. Every effort was made to draw a sharp line between the personal position of that individual physician, the official position of the Medical Association of Georgia and the position taken by proponents or opponents of a particular piece of legislation.

In addition to these individual contacts, the medical society invited all legislators to attend one county society meeting which did not involve either a scientific program or a political forum. Instead, it was an informal cocktail and dinner affair providing an opportunity for members of the society and legislators to enjoy themselves around mutually interesting topics. Political discussion was not limited nor was it the sole focus of discussion. Hunting and fishing tales were prominent.

We are indebted to one of our members for the suggestion that area legislators be invited to attend the annual joint meeting of the Muscogee County Medical Society and the Muscogee County Bar Association. The featured speaker for this occasion was Dr. Sabattier who addressed himself to the cult of chiropractic. The presence of a speaker on this topic was fortunate. We feel strongly that this is an excellent opportunity to meet with the legislators regardless of the topic of the evening. The last formal ingredient is one which was a part of every county society's program this year. The up-to-date flow of information from the Medical Association of Georgia legislative representatives was vital in coordinating information and activity at any given point in time.

Feminine Wiles

Having dissected the dry bones, we now turn to the vitality which pervaded the entire effort. What-

* Mrs. Maughon, wife of Bob R. Maughon, M.D., is legislative chairman of the Auxiliary to the Muscogee County Medical Society. Dr. Raines serves as medical director for the Bradley Center in Columbus.

ever errors physicians have made in the practice of the political art, they have succeeded monumentally in their marital efforts. The Muscogee County Medical Auxiliary formed a legislative committee characterized by beauty, vivaciousness, keen interest in the issues at hand and, with apologies to women's liberation, a generous portion of feminine wiles. Physicians and legislators alike were refreshed rather than burdened when contacted by these charming harbingers of political wisdom. One legislator, who will not be named, frankly acknowledged his delight in looking while he listened. The auxiliary hosted an informal cocktail and dinner for the legislators. Attendance was opened to all physicians and their wives but not required. The result was a small congenial enthusiastic group who met on one of the rainiest nights of a rainy season. The legislators' wives and the individual legislators both formally and informally communicated their enjoyment of this warm and friendly gathering. Once again there was no formal program nor any special emphasis upon political discussion. Small groups of auxiliary members made the vital personal visits to the state

capitol, visibly impressing the assembly with their involvement. Countless telephone calls, letters and personal reminders became the thing to do for this season.

Three impressions stand out above all others. Members of the society and the auxiliary came to know the respective wives and husbands of colleagues in a way that enhanced their mutual enjoyment and respect. All of us were impressed with the ready willingness of our legislators to listen, question and indeed make us feel as though we do have a voice in our democratic system. The marked increase in political activity of such a pleasant nature resulted in individual society members spontaneously initiating efforts to a far greater extent than in previous years.

We are left with the familiar phrase, "Wait until next year," but on this occasion it is in anticipation of more "Happy Politics" and not the disgruntled refrain of the loser who grudgingly returns to battle. We ask of those hardheaded realists who believe that the ultimate decisions still emanate from smoke-filled rooms, please do not educate us! We are proud, happy and excited. Have fun everyone, this is truly a game that the whole family can play.

2000 Sixteenth Avenue 31901

AMBULANCE OPERATORS MUST OBTAIN LICENSES

Ambulance operators who provide emergency care and transportation of sick, injured or wounded persons on public streets and highways of the state must apply to the Georgia Department of Human Resources for licenses to provide emergency service as of July 1, 1973, according to Dr. James W. Alley, Director, Division of Physical Health in the Department.

The licensing requirement is incorporated in an amendment to the Georgia Health Code (Chapter 88-31) which was enacted by the 1972 Georgia General Assembly and regulations adopted by the State Board of Human Resources in April of this year. It includes standards for vehicles, supplies and equipment, provides for inspections and sets criteria for the training of ambulance attendants and drivers.

Providers of ambulance services are being asked to give written notice to district health directors—through local health departments—of their intent to apply for licenses. Health representatives will then contact providers and assist with the preparation of applications.

According to the state health official, ambulances operated by the U. S. Government, invalid coaches and vehicles rendering temporary assistance in case of a major disaster are exempt from the regulations.

"The licensing requirement is a significant step toward improving emergency medical care for Georgia people," Dr. Alley said. "When its provisions are fully implemented, it should serve to reduce the death toll among victims of traffic accidents, heart attacks and other medical emergencies."

The author feels that we need a holistic approach to life in which both work and leisure are seen as expressions of man's search for a fulfilling existence.

The Meaning and Significance of Leisure

H. DOUGLAS SESSOMS, Ph.D.,* *College Station, Texas*

WHY DOES MAN EXIST? What is his function? Are we simply animals performing biologically, attempting to survive, or is our mission to find harmony with the elements, to be at peace with nature? Is it a search for immortality, the awareness and functioning of God within all, or are we the end of the evolutionary chain and ours is to order and master the environment?

Each generation has faced these questions and each in its own way has offered its reasons for being. Modern industrial man contends our function is to live useful and productive lives and for the masses, that has meant work: the activity that embodies all the duties and virtues of existence. It has allowed him to be active, to dominate the environment, to have power and dominion over all things—to progress.

Our whole social order has been built around the notion of work. Our schools, society's basic instrument of socialization, teach the tools necessary to survive in the industrial world. They prepare the young for the role of worker, to adhere to schedules and to work for rewards which come in the form of grades and gold stars—forerunners of wages and salaries. We organize our youth for tomorrow's activity, that they may become good workers. Listen to the content of our ads urging drop-outs to return to school. We want them to have better jobs, to be better workers, not to remain in school for the sake of learning.

Our religious institutions are work-centered. They have provided the moral backdrop for our social action and patterns. Since the days of Reformation, idleness has been suspect while action and production have been the marks of manhood and salvation. Even the notions of the dignity of work and the acceptance of one's calling have religious overtones. They are the basis for maintenance of an organized industrial society. Without the acceptance of these

values, how do we get the menial tasks performed? We all can't be kings and philosophers.

Like education and religion, government has functioned to support the work value system. Our laws against vagrancy, upholding the virtue of work, are a prime illustration. Definite biases have been held in favor of the producers and sellers of goods; only recently have the concerns of the consumer entered the political arena. It is not surprising that two national cabinet positions directly relate to those interests—labor and commerce.

Work Determined Worth

For some 300 years meaningful existence has been couched in terms of what one does with his life, his work, his calling, his mission. To quote Adriano Tilgher (*Homo Faber*), "the joy of work is the joy of feeling our activity victorious over the existence of the external world, the joy of feeling something becoming ours which at first was obstinately hostile to our will" (page 145).

Self-esteem, an element so vital to health, is largely based upon one's perception of the importance of what he does and how well he does it. We judge ourselves as we think others judge us. The high priority activities are those regarded most meaningful and give life its value. Work has been such an activity but concepts are constantly changing and our views are generation-bound. For example, there have been several distinct stages of the industrial revolution and each has had a tremendous effect on our concepts of work and the meaning of existence.

During the first period of the industrial revolution mechanization was the central force. Man developed machines which allowed him to extend his own power but rarely did his production exceed his ability to consume. Work was an integrative activity. There was great variability in one's rate of production. Each worker functioned as an artisan; his place of work was often his place of residence. The shop was manned by members of the family or the proprietor

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viewed his workers as his children and treated them accordingly. The machine improved man's ability to cope with the materials but did not alter his style of work. He essentially remained in charge of his day, such as today's craftsman and professional whose identity is intertwined with the product of his activity.

The second stage of the industrial revolution gave birth to the corporate society with its organization for mass production. In it workers no longer used machines as an extension of themselves but became like machines, elements of the assembly line. The genius of this stage rested in the ability of management to synchronize the interdependent parts so that the product appeared whole. The workers became specialists, with the accompanying loss of identity as the rhythm of work became the dictate of the production manager, not the laborer. Work became time structured; workers were paid by the hour, not by the job or piece. Effective management and efficient assembling resulted in higher rates of production, surpluses rather than scarcity, and the need to increase the level of consumption; or in the words of many, to improve our standard of living. For many Americans the two are the same.

Two Segments of Life

This new time structuring had a schizoid effect. Man's work was no longer integrative; his life was divided between work and non-work activity. Work became a means to an end rather than a way of life; yet, the value system which supported work as the essential element was still present. Consequently, his life style was altered. Weekends, vacations and holidays became important periods for they became the time available to pursue his pleasures, to use the goods he had bought to consume. He no longer had to live where he worked but could choose housing convenient to get to and from his job. Society began to stratify activities according to periods of life (youth, adult, old age), places of location (recreation centers, the office, the club) and groups (the lodge, the girls, the gang) with whom we interacted. The more we stratified, the more compartmentalized our lives became. As one might expect, our personal lives reflected the growth of the corporate society with all of its dependent and separate parts. Impersonality and alienation were natural by-products of the changing economic and social order. It is not surprising that we initially turned to mass entertainment and organized amusement as a means of filling some of the voids in our life. More recently many have turned to narcotics for the same purpose. Boredom became a national illness.

Cybernation, the third and current stage of the industrial revolution, brought with it the possibility of even more radical changes in our life styles. Automation, with its emphasis on communication and self-correcting mechanism, has had more than a revolutionary effect on worker behavior. It has reduced society's need for unskilled labor and for man functioning as a machine. It has increased the need for highly competent technicians at the beginning level of employment. We are all aware that we now enter the work force older and leave it younger. Changes abound: two-thirds of the jobs which existed in 1970 did not exist 30 years ago. Similarly, 60 per cent of the work activities we now know may not exist in 1980. "New careers" is more than a catch phrase; it's a way of life.

Transience and stimulus-overload, concepts discussed by Alvin Toffler in *Future Shock*, are concomitants to automation. We are told that each of us may expect to change our residence at least 12 times during our lifetime. IBM is affectionately known by its workers as I've Been Moved. Spectacular achievements have become so commonplace they lose significance. Look how complacent we've become at the moon flights and similar technological breakthroughs.

There are many consequences to the third stage of the industrial revolution. Chief among them is a shift in work patterns. The hard industries such as mining and manufacturing are declining in their relative involvement of the work force while the service industries expand (nearly 60 per cent of the labor force in 1970). According to Robert Dubin, a noted industrial sociologist, work has lost its meaning as a central focus for the blue collar worker. Conversely, his interest in his free time and self-expressive behavior has increased. Literally hundreds of thousands of young people, 18 to 21 years of age, are in school seeking meaningful roles and the mere preparation for a life of work is not enough. They want action "now" and tend to ally themselves with a variety of social revolutions and causes. It's not surprising that the number of applications to law school and the other social professions is increasing while the number of applications to engineering and business administration is declining.

We are literally creating new time blocks, new residential patterns, new consumptive behaviors, and new approaches to life. We are in the midst of a social revolution where the issue is not scarcity but of having so much around us that we know not where to start. Ours is the problem of abundance and that brings us to the specific focus of this paper—the meaning and significance of leisure. To me both leisure and work are expression of the same desire: the need for activity and meaningful existence. Their

form and priority are shaped by the values of society.

New Concept of Leisure

Until the advent of mass production, leisure was essentially a philosophical notion. The ancient Greeks and Romans discussed it in terms of obligation; leisure was the state of being in which man was truly himself, free from all incumbrances. Work was viewed as drudgery and obligation, but not in terms of a specific time set. The idea of leisure as free time is a modern concept and is a product of the second stage of the industrial revolution.

It was inevitable that the dividing of life into time segments would destroy the holistic and integrative aspects of work. Priorities of activity and time use were established with productive activity receiving the greatest social support. Free time took on legitimacy when it was used to consume the goods flowing from our increased productivity. Also, it was acceptable when participants pursued religious and educational activities; entertainment, amusement and diversionary activities were for children and the retired.

With more time to consume, leisure time became a period in which to express our personalities, to demonstrate our worth to others. For many this meant a display of our affluency, the rewards of our work. The kind of car we drove, the house in which we lived, the kind of barbeque grill we purchased, the size of our boat and motor, all of these have status value. But work remained the ultimate conferral of status, that is until. . . .

An interesting thing happened as a result of the division of life into work and leisure time. For many, work became a drudgery, something one had to do; his main satisfactions were coming from his leisure time experiences. He could hardly wait until the weekend to go camping, fishing or use his outboard. For others, work was still the greatest; it was satisfying and they could not understand why people wanted to waste their time pursuing recreation. Both, however, were caught up in the leisure movement and the impact of a growing leisure economy; all have felt the result of this dynamic. Time is available; recreation opportunities, in the form of equipment and resources, are being developed and used. *Play is satisfying* and individuals are finding fulfillment on the ski slopes or at the potter's wheel. Is work the only meaningful activity, the only expression of one's worth?

Before we get too far with this point let's look at one other aspect of American life during this period of mass production and the acceptance of leisure as non-work time. As a result of the developing bureaucracy and the huge organizations, the corpora-

tions and conglomerates, a mass society was established. It produced mass goods, required mass consumption and encouraged the desire for likeness. Our public was much more homogeneous 30 years ago than it is today. It was more willing to accept authority, the goods and services offered by the manufacturers, politicians, and educators. The urgency was to enjoy the "American Way of Life" and we all knew what that meant. It meant a better car, a better home, education for our children and security for old age. These were and still are noble goals but they are largely product-centered. Our ads portrayed a single image—the typical American. He was clean, middle-classed, smiling, youthful and attractive. Our magazines had general appeal. The stories of *Look*, *Life*, *Colliers*, and *Saturday Evening Post* were similar in format and content. They all appealed to this ideal American and deep down inside, we all wanted to be alike. Even our leisure patterns were similar. We wanted to go to the big resorts, to be entertained, to dance to the big bands, to have the same type of patio and cook-out equipment as our neighbors and wear the same style of "leisurelies."

Multi-Cultural Society

We were this way until the 1960's and for many, we still hold this to be the "American Ideal." That may be part of the frustration we feel when we see people who don't share our same perceptions of the American life style. We must remember, however, that we are a multi-generational and a multi-cultural society and that we probably were never as much alike as we thought we were, or as the mass media told us we were. Yet, few of us questioned the validity of these ads, that is until we became oversaturated with goods, until we suddenly discovered we had more options, more opportunity for diversity and found we enjoyed the company of fewer people than the aura of the mass cocktail party, the large dance and the big social club roster. Some began to reject the notion of organization as we began to reject the duality of the existence we had created. They began to question the value system which held that gratifications were to be deferred until the required tasks for the maintenance of life and the system had been accomplished. In doing so, they also began questioning the "good life" and the leisure patterns so closely associated with it: those who enjoy being entertained, the spectators; and those who pursue recreation with vengeance, consuming equipment and experiences in the process. Let me illustrate.

For some, leisure is time for amusement and the quality of the experience is often judged in terms of what is the cost. They are somewhat like the Ro-

mans of old, seeking the newer and more spectacular amusement but always leaving somewhat dissatisfied since theirs is a vicarious experience; their stimulation comes from others rather than from themselves. This is not to disdain amusement—I, too, enjoy being a spectator—but is an attempt to describe those persons who lack either the attitude or the skills necessary to become full participants in living, choosing nearly always to have someone else amuse them or schedule their free-time expression. Where does this seeking of the spectacular, the sensational episode, end? What do we do as an encore to *Oh, Calcutta!* or a multi-death smashup at Indianapolis? Certainly, our advancing technology will provide us with new and more varied sensory experiences with new sensations and amusements, but will these pursuants find satisfaction in being a spectator?

Pleasure of Possession

The second manifestation of this particular leisure behavior is seen in those who literally consume recreation environments and experiences. They are always buying new equipment, trying it out, demonstrating it, and abandoning it as newer and better models or newer forms roll off the assembly line. A few years ago I had the opportunity of working with the Outdoor Recreation Resources Review Commission. At that time boating was the rage and millions were pulling their boat trailers every available weekend. We discovered that people frequently would bypass a nearby lake to go to a more distant one to boat, even though the quality of the resource was equal. After some deliberation, we concluded that the reason they traveled the additional miles was that people would see them having fun and that they would have a greater feeling of having gone somewhere on an outing. To travel the lesser distance did not fulfill their need for these satisfactions even though it did allow more time for boating.

Since people seem to enjoy pulling something, we hypothesized that the next movement in outdoor recreation activity would also involve a trailer, and as you know, that has happened. Look at the tremendous growth in camping vehicles in the past decade. After all, both the boat and the camper can be parked in our yards to be seen by neighbors when they are not in use, and therefore, we derive additional benefit from the possession of equipment—people know that we know how to have fun. I wonder if this is often more satisfying to the collector of equipment than is the activity for which the equipment is intended.

Not all of those who seek outdoor experiences or own recreation equipment fit the above image.

Many do find satisfactions are related to the quality of the equipment they use and there's nothing wrong with a feeling of accomplishment for having succeeded to the point where you're able to possess these goods. My concern is that if people only pursue these experiences because they are consumers of goods, then the satisfactions must come from the shopping and possessing of the equipment rather than from the experience for which they are designed to facilitate. In some ways, the discount house has become a major recreation environment and provides hours of free time expression for those who get their kicks from the purchase, rather than the use of our products. Both these groups—those who wish to be amused and those who seek to consume—are time-oriented and equate satisfactions with money spent.

According to some writers, the time/work system we have known in the past is no longer acceptable or, at least, is no longer functioning effectively. Historians are now beginning to tell us that the 1960's was more than moon landings, civil rights conflicts, civil disorders, student unrest, drug abuse; it really must be viewed as a decade of attitudinal changes. We are in a systems revolution where the rate of change increases each day, where time has a new function and is ushering in a new era of time notions and values related thereto. Many are beginning to reject the duality of work and leisure and are defining leisure as self-imposed activities with a high degree of variability, not merely as free-time activities. This notion holds that leisure is freedom to pursue interests without reference to the time in which the activity occurs or whether goods are produced as a result of the experience. In some ways it is similar to our earlier concept of work as a holistic, integrating force; we are coming to accept that both leisure and work are the same: avenues of man's expression and fulfillment. One is not subservient to the other nor the result of the other.

Timeless Weekend

There are some who live in this concept of leisure, at least their behavior would suggest as much. They are those who approach their free time leisurely. They acknowledge the time limits of their experiences but during the moments in which they are at leisure, they act without reference to a clock. For example, they begin a weekend outing with a destination in mind but with no compulsion as to how they must use their time. They let the dynamics of the experience dictate their behavior. They eat when they feel like it or sleep as late as they wish or take side trips that were not planned. I've seen people enjoying this style, completely free from set routines and schedules, yet their leisure is acknowledged in rela-

tionship to other experiences and time obligations. Often, they plan for their leisure moments but never tie themselves to a specific set of activities which must be performed within those limits.

I have also seen these proponents of leisure at work. It is fairly typical of professionals and artisans who have control over their schedules. Their work tasks and leisure expressions may occur simultaneously or be interspersed.

We are only in the morning of this revolution, a revolt against our previous notions of time and organizational structures. As a part of it we are beginning to recognize the heterogeneousness of our population: for one group, work has become suspect; for another, it's a means to an end; for a third, unnecessary; and for others, an end in itself. Of course, we are still relying heavily upon the value system of the past to give direction to the future, but it is questionable as to how much longer we will and can afford to do this. Life in the 1980's will not be like the life in the '70s or '60s. There are a variety of forces at work and each has implications on the meaning of leisure and our emerging life styles. Let me illustrate.

First, let me return to my comments about popular magazines. The mass media approach no longer does it. *Look*, *Life*, *Saturday Evening Post*, and *Colliers* have gone their way. This is directly related to our giving up of the idea that we all are alike. We now seek those journals which pertain to our special interests and special group. All you have to do is to go to your local magazine rack and discover this for yourself. There are magazines for every interest: wine drinkers, auto enthusiasts, coin collectors, campers, hi-fi buffs, women's lib pursuants. True, television may be taking care of our needs for likeness but the evidence is clear—it is these special interests which turn us on. They are becoming life's central focus, and did you notice that none of these magazines have anything to do with our jobs?

Secondly, let us look at our reactions toward work. Although we recognize their necessity, most of us really dislike organizations and bureaucracy. Such popular works as *Up the Organization* and *The Peter Principle* support the belief that scientific management may be a thing of the past. Toffler, in *Future Shock*, offers us the notion of *ad hocism* as opposed to *bureaucracy*. He suggests that the increasing rate of change is forcing us to be problem rather than structure oriented, that crises and fads come so quickly we do not really have time to organize for action, only time to get a team together to handle the immediate scene, then disband until the next one demands attention.

Counter Culture

Let me digress a moment from these changing

patterns to reflect on a third major form of leisure behavior currently vogue in our society. I am referring to the counter culture groups who, to me, are a real enigma. In many ways they exhibit some of the same characteristics of those who consume recreation experience and compulsively wait to be amused and entertained. On the other hand, they seemingly have rid themselves of dependency on the clock and are in harmony with the rhythms of nature. They condemn the materialistic behavior of their parents, saying excessive horsepower is a pollutant while at the same time purchasing electronic amplifiers on the basis of wattage output—the more wattage, the better the amplifier. They reject the notion of fashions yet are very fashionable in their adherence to the uniform of their own group. They bemoan spectator sports and conventional entertainment as a narcotic while smoking marijuana and attending rock concerts.

This behavior is not very different from that of the larger society. Essentially, they are a product of the same value system, except for one notable exception: the counter culture groups do not honor our traditional time notion and its related concept of organizational interdependency. To the counter culturalists experiences are to be lived as they occur; they are to be enjoyed NOW. They are a different breed, or to put it in another context, they are pre-industrial men living in an advanced industrial society. Whether their ideas of work and their leisure behavior are the way of the future or only pockets of exceptionality, we do not know.

Let me now return to my discussion of some of the dramatic changes which are occurring which have implication for the immediate future. It is related to the increasing scarcity of our public property, our commons. Even our oceans and waterways can no longer be used indiscriminately; to protect them and to assure opportunity for all, we have to restrict our use of them with rules and regulations. This poses an interesting contradiction, that in order for each of us to have more freedom, we must pass legislation which limits our action. The concept of freedom is central to the American ideal; it is constitutionally guaranteed but has never implied license. It can only exist as long as the behavior of one individual does not infringe upon another. The concept of leisure as freedom from work, as a state of being, may be incompatible with a society based upon a system of interdependent time relationships. Who is to maintain the land, the recreation spaces for others to play? Who is to "keep the shop" and produce the goods for other to use? Who is to set the rules and enforce them that all might be free?

Certainly the decline of authority or at least the respect for authority is related to our rejection of the

mass society and over organization. Many see us moving to a state of anarchy and permissiveness, but I really believe we are simply rediscovering the authority of more intimate groups rather than rejecting the notion of authority *per se*. We do not want the organization to control us but rather wish to control ourselves, to be masters of our own fate. We now judge people in terms of their performance rather than the position they hold. We want to know what you can do rather than who you are and we judge what you can do in terms of our own interest and abilities to perform. Friendship lines and communication patterns are developing around leisure interests rather than work associations. The structures are still there but the form and focus are changing—freedom and responsibility are being redefined.

Workweek Shortens

Possibly the most dramatic change we are experiencing is in the development of new time concepts and new time schedules. Some years ago the six day work week gave way to the five day work week; this was largely due to the reduction of the number of hours one was to work. Today, we are moving towards the four day work week while still working the same number of hours as in the past. We are simply reorganizing the time block so that we work 10 rather than 8 hours each day, thus assuring us a three-day weekend each week.

Accompanying this is an increase in the number of vacation days each of us enjoys and the legitimacy of early retirement, if desired. Some employers are rationalizing this change on the basis of work efficiency but if we are honest, we would really have to admit that we do not need as many workers, proportionately, to carry out the functions of society as we did in former years. Longer vacations, more holidays and earlier retirement are good techniques to reduce the number of man/hours worked without decreasing the number of employees. Then, too, many of us believe that the 40-hour work week is only a prelude to a four-day, 32-hour work week. Essentially, what we are doing is reordering our lives so that we have large bulks of time at our discretion, time in which we control our own destiny. The implications are enormous, with a new set of structures and values in the offing.

Two distinct forms of leisure behavior seem possible as a result of these changes. The first will allow for more travel, more use of recreation equipment, more seeking of entertainment and amusement. It is an extension of what some of us are currently doing. We will seek new places to go, new ve-

hicles to use and new fads to follow. The multi-public concept will allow a variety of life styles and leisure activities to develop but none will be too different from today. There will be more adult education classes, more volunteer service opportunities, more special interest groups, more diversity and diversion, all governed by our present value system.

The other form our leisure may take is more closely allied to some of the behavior of our counter culture groups. I specifically am referring to their concept of leisure as a state of being and their rejection of organizational structures and bureaucracies. To them, they can take or leave work; it is not that important. What is more important is enjoying the world in which you live. Of course, there are some assumptions made about security and the willingness of somebody to provide these kinds of opportunities, and these are an extension of present thought, but the attitude of finding meaning in what you want to do with no priority as to the time in which the experience takes place is new. For this belief to take hold completely, some basic changes, particularly those related to our economic values, will have to occur.

Leisure = Freedom = Living

We are beginning to discover that the meaning of leisure is really the meaning of life, that leisure is freedom and freedom is living. Leisure is time to be you, to seek the activities which fulfill you, a time to love, to serve, to do what you wish within the framework of your interest group and to tolerate a similar freedom among those whose life styles you do not always understand or accept to live leisurely.

We are marginal men with this concept of leisure. We have one foot standing firmly on the ground of leisure as non-work time while the other is suspended over the land of leisure as activity without reference to time. In order to move firmly to the latter position we must lay aside the notion of leisure as being earned, as being diversionary, with work as man's sole purpose. We need a holistic approach to life where both work and leisure are seen as expressions of man's need for meaning. I have tried to indicate that this requires a modification of our attitudes and social structures, but are we not moving in that direction? I believe we are. The meaning of leisure is really the meaning of life and all that it truly embraces—the tasting, the touching, the sensing of the world in which we live. It is the recognition of the heights and depths of human experiences, the willingness to be more than a biological being. It is to be man in the truest sense of the word, each in his own way.

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The newly-revised act has been found to be ambiguous and calls for further, clarifying legislation.

'Civil Defense' and the Good Samaritan

CARL JELENKO, III, M.D.,* *Augusta*

DURING ITS 1973 SESSION, the Georgia legislature passed a revised Georgia Civil Defense Act (HB 385—Public Law 37—1973) which was signed by the Governor on March 15, 1973. The new law was ostensibly “. . . to redefine Civil Defense to include all emergencies and disasters or the imminent threat thereof, resulting from man-made or natural causes. . . .”

The need for a new, more liberal Civil Defense Law to recognize the current Federal charges to Civil Defense and the name change of the agency to Office of Defense Preparedness, is clear. Approximately one and a half years ago, with the advent of a new federal director of the agency, the Office of Defense Preparedness became able to respond to local situations which were not in and of themselves threats to the integrity of the United States or related to hostile enemy action.

Unfortunately, it appears that the Georgia Law developed to be consistent with the national purpose appeared to be too comprehensive, restrictive, and ambiguous in many key areas.

Conflicts

Some major concerns are, by implication, the conflict of this act with the Good Samaritan Law and those Good Samaritan Provisions of many other laws. In Section 14 of the Act it is stated that “All rescue organizations, associations, groups, teams, or individuals . . . shall be prohibited from performing any rescue or Civil Defense type activity until . . . certified by State Director of Civil Defense.” At Section 18 the Act reads “All laws and parts of laws in conflict with this act are hereby repealed.” Civil Defense is defined (Section 3) as “. . . the preparation for and the carrying out of all emergency functions . . . resulting from emergencies or disasters, or the

imminent threat thereof, of man-made or natural origin . . . civil disturbance, fire, flood, earthquake, winds, storms . . . or other causes. These functions include, without limitation, fire-fighting services, police services, medical and health services, . . .” etc. As defined in this Act, “Emergency means a sudden generally unexpected occurrence or set of circumstances demanding immediate action. Disaster means any happening that causes great harm or damage.” (Section 9)

At Section 3, the Act does invest the Governor with the power of “general direction and control of the Civil Defense Division” and the responsibility “for the carrying out of the provisions of this Act, and in the event of disaster or emergency beyond local control, the power to “assume direction and operational control over all or any part of the Civil Defense functions within the state.”

At Section 7, the Act gives the Governor the right to declare that a state of emergency or disaster exists. If he does so declare, the emergency and disaster response and recovery aspects of the state and its local political subdivisions are activated: but it is not clear, either by direct statement or implication, that the Governor is the *only* one who can declare that a state of disaster or emergency exists; or, indeed, that anyone must so declare!

On 21 April 1973, the MAG/EMS Committee considered this law in detail and requested an opinion of MAG's attorney; Maj. Gen. Joel B. Paris, III, State Civil Defense Director; and Arthur L. Bolton, Attorney General to the state of Georgia. Specifically, the Committee was concerned about the exceptional broadness of some areas within the bill which seemed to define Civil Defense in such a manner as to include within it the sum total and entirety of Emergency Medical Care and the totality of response in any and all emergency and disaster situations. The Committee was further concerned that the

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Bill, paradoxically, also was extraordinarily restrictive in certain of its provisions, constraining—even prohibiting—the provision of Emergency Medical Care or emergency care of *any* sort unless prior certification had been granted by the State Director of Civil Defense. Because of the extraordinarily broad definition of emergency and disaster and the lack of definition as to indication of the magnitude of the incident or the *absolute* designation of an individual to declare that emergency exists, it would appear that even such small incidents as a local self-contained fire, a child falling into a well, an automobile wreck would be emergencies and disasters—under Public Law 37—1973.

Attorney's Opinion

It was the opinion of Mr. J. Winston Huff, attorney for the Medical Association of Georgia, that “There is some conflict between the Good Samaritan and Georgia Civil Defense Statutes.” Mr. Huff does not think “that the . . . provisions . . . would apply to ordinary situations such as a highway accident or construction job accident.” He points out that both the “Civil Defense” situation and the Good Samaritan Statute requires rendering of emergency care “in good faith,” so that to this extent two statutes are coincident. However, in the situation where a Civil Defense emergency . . . as defined in the Act . . . exists, a physician might be held to be guilty of “willful misconduct” or “gross negligence”—and therefore, in jeopardy of lawsuit. Mr. Huff points out the Civil Defense Act has a standard repealer clause but does not specifically repeal the Good Samaritan Statute. It will be necessary to determine whether it was the intent of the General Assembly to do this—although it is probable that it did not.

In a telephone conversation with Mr. Billy J. Clack, deputy director of Civil Defense, on 7 May 1973—and again on 14 May 1973, it was indicated that, in the opinion of Civil Defense, Public Law 37—1973, does not inactivate fire departments, police departments, the Red Cross, physicians, and “other qualified people” from performing in an emergency or disaster. Civil Defense has not yet defined *who* is “qualified,” but Mr. Clack thinks there will be “no problem” with physicians being found “qualified.” He indicated in a telephone conversation that unqualified people include such individuals as members of Radio React, Inc., and others who “just come in and confuse the situation.” It was the MAG’s Emergency Medical Service Committee’s concern that this could include the civilian “Good Samaritan” who attempts to pull a victim to safety from a fire or auto-

mobile wreck or other such “disaster” or “emergency” as defined in the Civil Defense Act. Furthermore, Mr. Clack was unable to indicate the parameters of “qualification” *in writing* to Red Cross or the EMS Committee. Mr. Clack has stated that he will recommend that General Paris not issue such a statement at this time, either. It was further indicated by Mr. Clack that the State Office of Civil Defense would press for retention of the broad definitions of “disaster” and “emergency” and for the broad power to “respond” to any situation deemed appropriate by them.

Need for Legislation

The EMS Committee, through a resolution, approved by the MAG House of Delegates on 13 May 1973, urged that all physicians in the state of Georgia be informed through appropriate means of the implications of this Act “so that they can modify their behavior appropriately.” It was further approved that the MAG legislative committee seek to have enacted by the 1974 legislature appropriate legislation which would assure that there is no conflict between the Good Samaritan Act, the Good Samaritan portions of other acts and Public Law 37—1973. Further, the definition of magnitude of incident that calls Civil Defense into response and indication of the individual(s) empowered to declare a state of emergency or disaster will be sought.

On 7 June 1973, the Honorable Arthur K. Bolton, Attorney General, was requested by the State Director of Civil Defense to specifically consider possible conflicts in (Ga. L. 1962, p. 534) the so-called “Good Samaritan” Act and Act 37 (Ga. L. 1973, p. 74) the Civil Defense Act. The Attorney General’s “official” opinion is that, since no repeal was intended, and no irreconcilable conflict exists between the two laws, the Good Samaritan Act is still fully operative. This opinion is useful as a powerful advisory to the Courts, but *does not* oblige the Courts to so rule. Further, the other problems extant in the all-inclusive definitions of “Emergency” and “Disaster” in Act 37 are not resolved—or even addressed in the 7 June 1973 opinion. The role of police and fire services are not clarified—or even addressed; a definition of “qualified” is not considered; and the Civil Defense authorities have not indicated *who* declares situations to be appropriately the domain of Civil Defense.

It would seem appropriate and important to solve these dilemmas by requesting clarifying legislation dealing with these specific areas. In the meantime, it seems that the potential of great confusion—and even legal action—still exists.

Medical College of Georgia 30902

A new program of public education hopes to improve medical coverage at a vital time of life.

Newborn Insurance Can Lessen the Tragedy

JUDSON L. HAWK, JR., M.D., *Atlanta**

THE NEONATE IS OUR MOST valuable resource; with the necessity to control our population growth, quality of life is our mandate. Georgia has a poor quality of human reproduction—46th in the nation; this leads to our state ranking among the highest in premature births, high-risk infants, neonatal deaths and neonatal morbidity related conditions.

Intensive care in the immediate newborn period is of paramount importance to the overall problem. Intensive care facilities are now available throughout our state on a limited basis. Regional care of the newborn, a part of Georgia's Regional Medical Program, has planned a most sophisticated set up—on paper. This care is costly; no dollars are presently funded passed the planning stage. Money spent in the immediate neonate period in giving intensive care to the high risk neonate has proven to give an excellent return on the dollar. It now costs the state \$13,000 to keep one patient one year in one state institution. Not only would this care save future custodial dollars, it would save much human suffering.

Hazardous Exclusion Causes

It is estimated that 85 per cent of our population has medical insurance, but most young parents do not realize that exclusion clauses are written into many of these policies. These exclusion clauses may exclude the first week or two of an infant's life and may thereby exclude him from medical coverage for the rest of his life. Unfortunately, we as doctors know, this may therefore exclude excellent medical care at a most vital time of an individual's life or may cause a financial catastrophe which a young family may never be able to overcome. Costs of \$200 to \$400 a day in an intensive care unit is not unusual.

We have the medical knowledge to save many of

these infants at high risk and reduce or prevent most of the morbidity related conditions. We have already excellent intensive care units and a most sophisticated statewide plan for the future. We certainly have the neonates who need this care *but* we do not have the dollars.

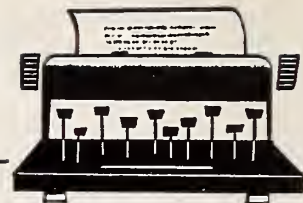
The Georgia Chapter of the American Academy of Pediatrics brought this medical need to the attention of the Medical Association of Georgia. A special task force on Newborn Insurance Coverage was appointed and the following plan is being implemented. A statewide program via radio, television stations and newspapers will be pushed to educate doctors and parents of the existence of these exclusion clauses. Labor unions, insurance companies and employers will be contacted. It is our goal to muster enough public opinion concerning these exclusion clauses that the insurance companies will voluntarily remove them because no one will buy a policy if such a clause exists. It has been estimated that if every policy with dependent coverage, written, sold or renewed in Georgia covered the newborn from the moment of its birth, it would increase the cost only 25 cents more each month per family.

Educate Patients

We need the support of every doctor in our state to educate his patients of the existence of these discriminatory clauses in insurance policies. They exist because the insurance companies can sell the employer or family a policy at a reduced rate. At a most important time, an individual's life and future is being negotiated.

If we can remove the existence of these exclusion clauses, 85 per cent of the funding problem for Regional Care of the Newborn can be solved. This will go a long way in improving the quality of life for Georgia's future citizens.

* Chairman of the Executive Committee, American Academy of Pediatrics and chairman of the Task Force on Newborn Insurance coverage of MAG.



New Officers Elected at Annual Session

LESLIE COOPER BUCHANAN, Decatur, was elected vice speaker of the House of Delegates at the 119th Annual Session in May, filling the unexpired term of John Rhodes Haverty, who resigned to run for the office of president-elect.

Dr. Buchanan serves as councilor from the DeKalb County Medical Society, is on the Board of the Georgia Medical Care Foundation and is a GRMP advisor from District 4. He serves on MAG's Insurance and Economics Committee and is on the nominating commission for medical doctor appointments to the Board of Human Resources.

The Georgia native was graduated from Emory University School of Medicine. He is married to the former Bonnie Mary Turner.

Second Vice President

Newly-elected second vice president is Luther M. Thomas, Jr., of Augusta, current president of the Richmond County Medical Society.

Dr. Thomas was born in Macon and attended George Washington University, the University of Georgia and the Medical College of Georgia. He has maintained ties with the medical school and has served as instructor and assistant professor on a part time basis.

The internist is a member of the West Augusta Rotary Club, and the First Presbyterian Church. He and his wife, Elizabeth Jane Thomas, have three children.

AMA Alternate Delegate

Assuming duties as AMA alternate delegate for the unexpired term of Henry S. Jennings is Luther M. Vinton, Jr. of Avondale Estates.

Dr. Vinton was born in Atlanta and educated at North Georgia College, the University of Georgia and the Medical College of Georgia. His practice has been in general practice and emergency medicine.

Dr. Vinton has served as vice president and president of the DeKalb County Medical Society, chaired many committees and serves as editor of its *Bulletin*.

He has been chairman and vice chairman of the Georgia Medical Political Action Committee and is now a member of the committees on Legislation, Professional Conduct and Ethics, Emergency Medicine and Annual Session. He is a representative to the Interprofessional Council and is a vice-councilor from DeKalb County.

Dr. and Mrs. Vinton, the former Patricia Ann Tutton, have two children.

Report on AMA Conference

THE MAG WAS WELL REPRESENTED at an AMA Conference on PSRO in Washington, D.C., May 23. The MAG delegation was led by President C. E. Bohler, M.D., and included F. W. Dowda, M.D., L. C. Buchanan, M.D., J. A. Kaufmann, M.D., Jim Moffett, and Adam Jablonowski, MAG Staff.

The 120 representatives of state medical associations not only met together to

discuss PSRO strategy, but also heard from William I. Bauer, M.D., director of the Office of Professional Standards Review and Henry I. Simmons, M.D., deputy assistant secretary for health of HEW. The main thrust of the day, however, was the face to face meetings which occurred between the medical association representatives and members of their state's congressional delegation.

The MAG officers and staff met with Senators Herman Talmadge and Sam Nunn and also met with Representative Phil Landrum. The object of these sessions was to convince the Congressmen that state medical associations should be given the opportunity to function as statewide umbrella PSRO agencies. Great emphasis was placed on the recognition of local peer review activities as the only viable means for providing quality and cost control over the Medicaid and Medicare programs. It was pointed out, though, that not all areas were prepared to engage in such a large scale operation as PSRO. The MAG delegation suggested that especially because of the state association's experience with CHAMPUS, Regional Medical Program, EMCRO, and the Foundation, it would probably be of great benefit to HEW as well as the developing local peer review organizations in Georgia to have a statewide organization functioning as an umbrella PSRO coordinating agency.

These personal contracts with Georgia's Congressmen have been followed up with letters and additional information on MAG's position. We have urged them to use their influence with the HEW officials who will be developing guidelines, rules, and regulations for PSRO to assure that state associations are allowed a coordinating role.

NINTH ANNUAL GEORGIA RURAL HEALTH CONFERENCE

August 29-30, 1973

Macon Hilton

"The Changing Role of State Government in Health Care and Environmental Services"

WEDNESDAY: Panel Discussion

"Makeup and Operation of the Department of Human Resources"

Gary Cutini, Life Insurance Company of Georgia

"The Public's View on State Government in Health Care"

R. S. "Rock" Howard, Environmental Protection Division

"Changing Patterns of Environmental Control"

Lt. Governor Lester Maddox

"How Legislators See Their Role"

THURSDAY: George F. Green, M.D., Sparta

"The Role of the Physician Assistant"

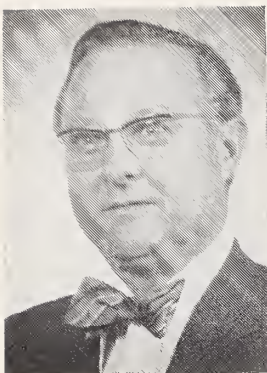
John Rhodes Haverty, M.D., Dean, School of Allied Health Sciences, Georgia State University

"The Role of Allied Health Personnel"

W. Newton Long, M.D., Professor of Gynecology and Obstetrics, Emory University School of Medicine

"The Role of a Nurse Midwife"

Co-Sponsored by: The Medical Association of Georgia and the Georgia Farm Bureau Federation with assistance from the Cooperative Extension Service of the University of Georgia.



EMCRO: AN UPDATE

SINCE EMCRO was a controversial issue during the 119th Annual Session in May, The President's Letter this month will be devoted to this subject. The financial aspects of the program will be forthcoming after the end of the fiscal year, and I do not have that information at this time.

Lowell Foster is the director of our EMCRO project. I have asked him to outline briefly EMCRO's current activities. His report follows:

"You will recall that EMCRO (Experimental Medical Care Review Organization) is a federally funded project of the Medical Association of Georgia, whose purpose is to develop objective means of evaluating quality of medical care. EMCRO has developed—and is beginning to test—two data systems: 1) a centralized review system for nursing homes, and 2) a hospital discharge abstract system. These systems will assist physicians in reviewing quality of medical care as well as provide management data and JCAH required indexes to the facilities.

"I encourage all of you to work with the EMCRO in the coming months. Those of you who have been involved with the EMCRO and see its value will, of course, continue to do so. Those of you who question its value should find out more about it, modify it, improve it. Twelve specialty societies, MAG's Committee on Geriatric Medicine and the Interspecialty Council have worked with the EMCRO to date. But the input of only 100 physicians is not enough. Those of you with questions or suggestions about EMCRO should ask to be represented on your specialty panel. Those of you who sit on hospital or nursing home review committees should take advantage of the coming months to monitor the EMCRO systems in your own facilities. Review the criteria and the exception reports—make the system live up to its promises.

"The criteria developed over the past 12 months will be modified by the specialty panels in the Fall of this year. This modification will be based, in part, on the panels' analysis of the data to be collected by these systems over the next few months. Field tests of both systems began July 1. Medical staffs of facilities desiring to participate in these field tests should contact MAG."

A handwritten signature in dark ink, reading "Charles E. Bohler, M.D." with a stylized flourish at the end.

Charles Emory Bohler, M.D.
President, Medical Association of Georgia



BREAST CANCER DETECTION DEMONSTRATION PROJECT

**R. WALDO POWELL, M.D., and
A. HAMBLIN LETTON, M.D., Atlanta***

IS MASS SCREENING for breast cancer a practical and feasible idea? We now have a unique opportunity to find out. During the first year approximately 5,000 women will be screened at Georgia Baptist Hospital and at Emory University, using the techniques of mammography or xerography, thermography and physical examination of the breast. These women will be asymptomatic and 35 years of age and over.

Atlanta is one of the three initial cities originally selected in January to launch a nationwide Breast Cancer Detection Demonstration Project. The National Cancer Institute and the American Cancer Society, which are jointly sponsoring the program, have awarded grants totaling \$360,944 to the Atlanta project for the first year. Screening began at Emory on July 1 and will begin at Georgia Baptist on September 1 unless purchase of equipment and building alterations can be completed sooner.

Eventually, 20 such demonstration projects will be established. In each of these, 5,000 or more asymptomatic women will be screened annually by means of clinical examination, plus mammography or xerography and thermography. Medical histories will be taken and follow-ups done. Patients will also be taught Breast Self-examination. There will be no charge to the patient for any of these services.

The idea and planning for this remarkable cooperative venture came out of the ACS National Task Force on Breast Cancer. As pointed out recently by the ACS publication *Cancer News*, the situation is similar to the early days of the PAP test. At that time the late Dr. George N. Papanicolaou had come up with a diagnostic test for cervical cancer but physicians needed to be convinced of its value; professionals had to be trained to administer it and technicians trained to screen the smears. Also, women needed to understand the test's importance.

Today, PAP test is part of our language. Can the same be done for mammography, xerography or thermography? Through its volunteers and vast public education and information activities, the American Cancer Society will endeavor to teach the meaning and importance of these terms. Also, the demonstration projects will provide a data base for sound decisions concerning the use of these techniques for mass screening of a high-risk population.

The American Cancer Society is closely involved in the project in all of its phases. ACS volunteers will help recruit women for the screening. Standard forms developed in the ACS and NCI National Headquarters will be used. Records will be maintained locally and copies will be forwarded to a central statistical center for data accumulation and retrieval.

Appointments for examination will be made through receptionists at Georgia

* Dr. Powell, project director of the Early Detection of Breast Cancer Project in Atlanta, is associate professor of surgery at the Emory Medical School. Co-director of the project is Dr. A. Hamblin Letton, president of the Atlanta Medical Center and chief of staff and attending surgeon at Georgia Baptist Hospital. Dr. Letton is immediate past president of the American Cancer Society, Georgia Division.

Baptist Hospital and at Emory. An estimated 16 patients will be screened each day at Georgia Baptist. About four will be examined daily at Emory in the screening portion and four others in the comparative study of symptomatic women. The plan calls for 4,000 asymptomatic women to be examined each year at Georgia Baptist and 1,000 at Emory.

Our plan calls for at least four procedures on each patient. This will include a history, clinical examination, thermogram, and either a xerogram or mammogram. Each patient who has a positive or suspicious finding will be referred to her private physician (or to a hospital or clinic which she designates).

Frequent Follow-Up

A report will be forwarded to the designated physician or clinic together with a request for follow-up information in regard to the pathology found and treatment given. If this information is not returned, a follow-up by mail or telephone will be instigated by the project secretary. Patients who are found to have cancer of the breast will be entered in the cancer registry of the hospital in which they are treated and followed periodically by that registry.

Emory personnel will train technologists and physicians in all techniques and examinations and will continue to act as consultants to those involved in the project. Although technologists will perform many of the tasks, including the screening of mammograms, xerograms, and thermograms, quality control will be attained by regular checks on the adequacy of all phases of the project in which technologists participate. This entails daily checks on history, physical examination, mammography, xerography and thermography as to quality of studies and adequacy of screening. All suspect findings by any of the screeners (technologists) will be reviewed by a physician and a report forwarded to the family physician or institution designated by the patient. Ten per cent of negative examinations (physical, xerography, thermography, mammography) will be checked by an M.D.

Interest in cancer at Georgia Baptist Hospital and at Emory has been of long standing. The Sheffield Cancer Clinic at Georgia Baptist has been in operation since 1934. The Robert Winship Memorial Cancer Clinic at Emory was established in 1937. Georgia Baptist is the largest private hospital in Georgia, serving over 27,000 patients each year. It was founded in 1903. The Georgia Baptist Hospital is now an Area Cancer Facility and Emory a Regional Cancer Facility of the Georgia Regional Medical Program. Members of the staff of both hospitals have been active in the Georgia Division and the national organization of the American Cancer Society.

The early detection of breast cancer by mammography has been a project at Emory for many years. It began in 1960 under the direction of Dr. James V. Rogers and Dr. R. Waldo Powell. In 1964 Dr. Robert L. Egan, one of the pioneers in the field, joined the Emory staff as Chief of the Section of Mammography. Continued refinement of the mammography technique, whole organ breast microscopic study, x-rays of biopsy specimens, correlation of clinical, microscopic and radiographic findings and cooperative efforts of surgeons, radiologists and pathologists have provided at Emory a unit admirably suited to further studies of new techniques of breast cancer detection.

Grants awarded to the Atlanta project include \$177,341 from NCI; \$69,300 from the American Cancer Society's National Office; and \$114,303 from the Albert E. Elliott Memorial Fund—a legacy to the DeKalb County Unit of the Georgia Division, ACS.

In addition to Atlanta, Louisville, Kentucky and New York City were in the initial group to be selected for the project. Eight additional cities have since been named: Newark, N.J.; Kansas City; Milwaukee, Wis.; Boise, Ida.; Jacksonville, Fla.; Cincinnati, Ohio; Oklahoma City and Seattle, Wash.

1365 Clifton Road, N.E. 30322



DIRECT CORONARY REVASCULARIZATION

FRANK L. FERRIER, M.D., *Marietta and Atlanta**

CORONARY ATHEROSCLEROSIS is a diffuse and obstructive disease of metabolic origin. It involves the left anterior descending, right, and circumflex coronary arteries in unlimited variation. Uncommonly does one find single vessel disease for usually two or more vessels are involved.

Angina pectoris is the single most important manifestation of coronary heart disease. Unfortunately many patients with angina die prematurely and an even larger group are disabled. It is little wonder that autogenous saphenous vein bypass surgery and direct internal mammary artery surgery will continue to dominate the field of cardiovascular surgery in the years to follow.

Patient Selection Criteria

Lest we become too involved with these operations as the surgical panacea of the decade one must establish strict criteria for patient selection based on firm clinical and experimental grounds. Patients are considered candidates for direct revascularization if they suffer with severe disabling angina not refractory to medical therapy. In such patients selective coronary angiograms usually demonstrate stenosis greater than 75 per cent of one or more vessels with patent distal arteries. Mitral insufficiency secondary to rupture of papillary muscle or chordae tendinae require mitral valve replacement. Interventricular septal infarction and rupture demand closure of the defect. Finally, ventricular aneurysm or areas of asymmetry with patent distal runoff require resection and revascularization. Those patients with diffuse disease and poor distal runoff are best considered inoperable. This is usually accompanied by scarred myocardium, elevated left ventricular end diastolic pressure, and depressed cardiac index.

Having selected the appropriate patient, a reversed segment of saphenous vein is used to bypass the area of atheroma. This involves cardiopulmonary bypass with left ventricular decompression. Generally the aortic anastomosis is performed off the heart lung machine while the distal anastomosis is carried out on the pump with the heart decompressed and the aorta crossclamped. Coronary arteries which admit a 1-3 mm probe are anastomosed end to side or side to side to the reversed vein using 6-0 suture. Also bypass grafting to the internal mammary artery can now be performed using optical magnification and microsurgical techniques. The internal mammary artery which closely approximates the size of the distal left anterior descending or circumflex coronary artery is sutured using 8-0 or 9-0 nylon. By eliminating one anastomosis the pump time is less and probably the occlusion rate is reduced. In addition to surgery for the left anterior descending and circumflex coronary vessels, the splenic artery has recently been anastomosed to the right coronary on the diaphragmatic surface of the heart. Satisfactory graft flows may vary anywhere from 50-110 cc per vessel. Flows less than 45 cc are the result of poor surgical technique or a limited capacity of the diseased distal coronary conduit to accept higher flows.

The overall operative mortality regardless of numbers of vessels involved is 2 to

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

10 per cent across the country.¹ Long term graft patency (2½ yrs.) is 86 per cent using saphenous vein bypass.¹ However, it appears that the long term patency rate of the internal mammary artery direct anastomosis will be twice that of the vein grafts.¹

Questions and Answers

What then can be expected from direct coronary revascularization? Relief of angina is accomplished in the great majority of patients thus improving the quality of life. Bypass surgery may prevent further occlusion and its sequelae. Questions that are not answered are related to protection from myocardial infarction and prolongation of life. Unfortunately, there is no data available since the follow up time has been too brief.

If the patency rate of the autogenous artery or vein graft continues to improve at a faster rate than the natural history of patients with disabling angina perhaps these questions may be answered. One then wonders if our patients would die of coronary insufficiency with two or more patent grafts in major coronary arteries?

*754 Cherokee St. S.E. 30060
3250 Howell Mill Rd. N.W. 30327
Suite 303*

REFERENCE

1. W. Dudley Johnson, M.D.: Personal communication.

PATHOLOGY TRAINING INSTITUTE COMES TO ATLANTA

Atlanta has been selected as the site for one of 20 National Training Institutes of the American Society of Clinical Pathologists. The training program is scheduled for September 27-29, 1973 at the Royal Coach Hotel.

The 100 participants expected will divide up into four workshop areas: 1) laboratory identification of enterobacteriaceae; 2) quality control and clinical chemistry; 3) laboratory identification of dangerous drugs; and 4) advanced studies in abnormal hematology.

Participants will be drawn from the ranks of instructors in collegiate and junior college programs as well as in medical laboratory schools and clinical laboratories. Announcements will be sent to schools for medical laboratory personnel as well as to directors, chief medical technologists and supervisors of clinical laboratories approved for Medicare. In order to help defray expenses of attending the Institute, \$32 will be made available to each participant.



IS THE CAPTAIN OF THE SHIP DOCTRINE SINKING?

JERRY R. CARTER, *Atlanta**

THE SO-CALLED "CAPTAIN OF THE SHIP" doctrine historically has insulated hospitals from liability for the alleged negligent conduct of physicians utilizing hospital facilities. This doctrine, which is based upon the premise that physicians are to be deemed independent contractors while treating patients, has, however, been subject to erosion in recent years.

The rationale of this exculpatory doctrine is that physicians who exercise their art within a hospital are to be deemed independent contractors rather than employees. Thus, the legal theory of *respondeat superior*, or "let the master answer," has had no application in connection with the relationship between hospitals and their staff physicians, in contrast to the customary responsibility of employers for the negligent acts of employees.

Administrative Vs. Medical Functions

The genesis of the independent contractor doctrine is generally ascribed to an early New York decision¹ in which a distinction was drawn between "administrative" and "medical" functions of hospital personnel (including physicians and nurses), with hospital liability ascribed for acts deemed to be within the former category and denied for acts in furtherance of the latter function, such "medical functions" being deemed to be performed not by hospitals but by physicians (or by nurses under their direction) acting as independent contractors. This distinction proved to be rather vague in application and in due course gave rise to decisions which departed from practical realities and often produced disparate results lacking in logical or legal consistency.

Also put forward in *Schloendorff* and its progeny was the notion that a hospital, as it is of course not licensed to practice medicine, may not be said to "treat a patient"; that function must be deemed to be within the responsibility of a practicing physician. Thus the physician, not the hospital, is the party answerable for negligent conduct.

In a recent decision,² the Court of Appeals of Arizona directly confronted and re-examined the question of the responsibility of hospitals for the acts or omissions of staff physicians in the treatment of patients within the confines of hospitals. The Court's conclusions may be of far-reaching significance to the economics of hospital operations.

The factual context of the litigation, a fairly representative situation, involved an action against a hospital as a consequence of the alleged negligence of the hospital's resident radiologist in the course of his performance of an x-ray procedure.

The hospital attempted to avoid all responsibility for the acts of the radiologist by reliance upon the independent contractor doctrine. In *Beeck*, the Court indicat-

* Prepared at the request of The Medical Association of Georgia. Mr. Carter is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

ed its understanding that the principal ingredient of this doctrine is the long-standing premise that a physician's vocation requires such a high degree of technical skill, and the exercise of such a wide range of discretion in making judgments as to the course of a patient's care, that a hospital (or an individual such as a hospital administrator) may not, without dire consequences to the well being of a patient being treated, exercise meaningful supervision over the medical decisions or conduct of a practicing physician.

The Court, however, placing principal reliance upon a New York decision,³ and an Illinois decision,⁴ held the hospital liable for the negligent conduct of its resident radiologist.

Employer-Employee Relationship

In reaching its conclusion, the Court dwelt at length upon the various facets of the relationship between the radiologist and the hospital which tended to strongly color such relationship as that of employer-employee. For example, the radiologist was compensated by the hospital from the revenue of the x-ray department, and received no other compensation; the hospital billed his patients for his services; and the radiologist had agreed with the hospital not to engage in private practice while in charge in the hospital's x-ray department. Additional reliance and emphasis was placed upon the apparent lack of choice by the patient as to the physician who performed the needed x-ray procedures. Apparently, the patient's communication was exclusively with the hospital; i.e., a doctor-patient relationship between the radiologist and the patient could not be said to have existed in any meaningful sense.

Thus, based upon the nature of the relationship of this staff radiologist to the hospital which afforded him the tools of practice and directly furnished his compensation, the Court concluded that an employee-employer relationship did in fact exist between the radiologist and the hospital, and that the hospital was therefore responsible for his actions.

The New York Court of Appeals, in its opinion in the *Bing* case, wherein the administrative/medical test set forth in *Schloendorff* was rejected, offered the following characterization of the hospital operations:

"The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act of their own responsibility.

Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue exemption from the universal rule of *respondeat superior*. The test should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment."⁵

The *Darling* case, decided in Illinois in 1964, also evidenced departure from the traditional rules of hospital liability for errors in the treatment of patients. The de-

fendant hospital in that case was held to be responsible for the negligent conduct of the physician involved, despite the fact that the physician was clearly independent from the hospital, and had merely exercised his privilege to utilize hospital facilities in the treatment of a private patient.

Failure to Supervise

The Court, however, looked to the hospital's own by-laws or standards of practice and to the accreditation code of the association in which the hospital was a member to arrive at the conclusion that the hospital had been *independently* negligent in failing to supervise (more specifically, to require consultation with a specialist by the general practitioner) the treatment afforded the patient by the physician.

The *Darling* Court worked a significant departure from the traditional independent contractor doctrine by assigning liability to the hospital, *as a corporate entity*, for negligently performed treatment of a patient occurring within the confines of the hospital, despite the fact that the hospital (and most other hospitals within the area) under its customary procedures exercised no control or supervision over the medical treatment decisions made by the physician.

Obviously, the *Darling* decision opened a new avenue for the imposition of liability upon hospitals throughout the country. This decision has not been followed to any great extent as yet. However, it does suggest that hospitals must be quite careful in granting and continuing staff privileges and in insisting that physicians who practice there closely follow hospital rules and routine.

A potentially troublesome derivation of decisions such as *Darling* and *Beeck* is the fact that if staff physicians are to be deemed "employees" for the purposes of hospital tort liability, then they are eligible under federal statutes to form labor unions, as has already occurred in hospitals in some areas. Consequently, the spectre of strikes by staff physicians for better working conditions, less bothersome administrative duties and higher wages or fringe benefits may be presented.

It should be emphasized that the above cases represent rather special situations. In one case, the doctor (the radiologist) was paid by the hospital and was not actually engaged by the patient. In the other, the hospital did not see to it that its own rules were followed. We could find no case as yet where the hospital was held liable solely on the basis of the malpractice of an independent staff physician. Yet the departure these cases represent from the old rule may lead in the future to further erosion.

Eleventh Floor

C & S National Bank Building 30303

REFERENCES

1. *Schloendorff v. Society of New York Hosp.* 211 N.Y. 125, 105 N.E. 92 (1914).
2. *Beeck v. Tucson General Hospital*, 18 Arizona App. 165, 500 P.2d 1153 (1972).
3. *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3 (1951).
4. *Darling v. Charleston Community Memorial Hosp.*, 33 Ill.2d 326 211 N.E.2d 253 (1965).
5. *Bing*, 163 N.Y.S.2d at 10, 143 N.E.2d at 8.

THE ASSOCIATION



NEW MEMBERS

Adickes, Frederick H. Active—Glynn—P	5 Retreat Place St. Simons Island, Georgia 31522	Harper, Kenneth A. Active—Ga. Medical—PI	5105 Paulsen St. Savannah, Georgia 31405
Aguilar, Juan J. Service—Laurens—Su	VA Hospital Dublin, Georgia 31021	Joshi, Arun D. Active—Ga. Medical—EM	P.O. Box 6688, Station C Savannah, Georgia 31405
Apanay, Manalo B. Active—Clayton-Fayette—Su	1019 Astor Avenue Forest Park, Georgia 30050	Kugler, Morris A. Active—Ga. Medical—Su	1 Medical Arts Center Savannah, Georgia 31405
Askew, James L. Active—Clayton-Fayette—R	Box 21 Riverdale, Georgia 30274	Kumin, Gerald D. Active—MAA—I	33 SW Upper Riverdale Rd. Riverdale, Georgia 30274
Baker, Charles R. F., Jr. Associate—MAA—Su	69 Butler St., S.E. Atlanta, Georgia 30303	Kurzbach, Elmer Active—Ga. Medical—FP	314 E. Gaston St. Savannah, Georgia 31401
Berenguer, Ramon C. Active—Baldwin—FP	Central State Hospital Milledgeville, Georgia 31061	Lau, Fook S. Active—Baldwin—I	Central State Hospital Milledgeville, Georgia 31061
Bethea, James S., III Active—MAA—Or	478 Peachtree St., N.E. Atlanta, Georgia 30308	Leonard, Robert P. Active—MAA—PI	960 Johnson Ferry Rd., N.E. Atlanta, Georgia 30342
Brown, Alan P. Active—Ga. Medical—Em	P.O. Box 13312 Savannah, Georgia 31406	Montalvo, Carlos Active—Baldwin—Pd	Central State Hospital Milledgeville, Georgia 31061
Cabrera-Cicero, Orlando Service—Laurens—Su	VA Hospital Dublin, Georgia 31021	Pagsisihan, Francisco M. Active—Oconee Valley—Su	123 Jefferson St. Madison, Georgia 30650
Collier, Harold R. Active—Ga. Medical—FP	904 W. Broad St. Savannah, Georgia 31401	Shama, Z. A. Active—MAA—Su	478 Peachtree St., N.E. Atlanta, Georgia 30308
Delatorre, Jose M. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31061	Speriosu, Simon V. Active—Ga. Medical—P	1202 Brightwood Drive Savannah, Georgia 31406
Dew, James H., Jr. Associate—MAA—Oph	53 Park Circle, N.E. Atlanta, Georgia 30305	Valbuena, Dominiciano A. Active—Ga. Medical—Anes	36 Medical Arts Center Savannah, Georgia 31405
Feinerman, Lois K. Active—Cobb—D	1680 Mulkey Rd. Austell, Georgia 30001	SOCIETIES	
Feinerman, Michael B. Active—Cobb—PI	1680 Mulkey Rd. Austell, Georgia 30001		
Feingold, Alan O. Associate—MAA—I	80 Butler St., S.E. Atlanta, Georgia 30303	The Georgia Medical Society heard an address from Dr. Carroll Quinlan, chief of the Chronic Disease Activity division, U.S. Public Health Service at its mid-June meeting. The 1972 president of the society, Dr. Darnell Brawner, was given a special tribute at the meeting.	
Garcia, Antonio J. Active—S. Ga.—P	2601 Bemiss Rd. Valdosta, Georgia 31603		
Garcia, Benito Active—Baldwin—FP	Central State Hospital Milledgeville, Georgia 31061	The Glynn County Medical Society has issued a statement protesting the fact that county physicians have not been included in a new Area-Wide Comprehensive Health Planning Council appointed by the Coastal Area Planning and Development Commission. The Society had submitted three nominations for the Council following a request for names by the CAPDC.	
Gongaware, Robert D. Active—Ga. Medical—Su	200 E. 31st St. Savannah, Georgia 31401		
Gongaware, Theodora L. Active—Ga. Medical—I	P.O. Box 6688, Station C Savannah, Georgia 31405	The Medical Association of Atlanta has appointed Jim B. Grant of Douglasville as general manager of its subsidiary, Medical Society Services, Inc., which offers	

several communications and administrative services to MAA physicians.

Muscogee County Medical Society, with support from Lederle Laboratories, completed its first annual Doctors' Double Tennis Tournament in June which was held due to widespread interest in the sport among society members. Winners were Walker Harris, who took first place in the MAG Annual Session tournament, and George Lipscomb who together defeated Dan Newberry and Bill Hayes. The society challenges others to sponsor doubles teams for a day of Round Robin Tennis. Those interested should contact Marvyn D. Cohen, M.D., 1968 North Avenue, Columbus, Ga. 31901.

PERSONALS

First District

C. Emory Bohler, Brooklet, new president of MAG, has been elected to the Board of Directors of the Bulloch County Hospital.

A. B. Daniel and **William Kent** have been named to a five-member Physician Recruitment Task Force established by the Statesboro-Bulloch Chamber of Commerce.

Galen C. Huffman, assistant medical superintendent at Georgia Regional Hospital in Savannah, has been selected for inclusion in the 1973 edition of *Who's Who in Georgia*.

Savannah's **Jane B. Jennings**, director of the laboratory at Memorial Medical Center, received the Algernon Sydney Sullivan and Mary Mildred Sullivan Awards for 1973 from Erskine College Alumni Association in Due West, S.C. The Sullivan Awards honor an alumnus and an alumna who have "manifested such qualities of heart, mind and conduct as evince love for and helpfulness to other men and women."

William H. Lippitt, a Savannah surgeon, will spend two months this summer teaching young interns and doctors in Maceio, Brazil when he joins Project Hope, the worldwide health program.

James C. Metts, Jr. has been featured in an article in the May 20 issue of *The Atlanta Journal and Consti-*

tution Magazine which dealt with the incidence of stroke in Savannah.

Irving Victor, Savannah, has been named president of the Board of Trustees of the Medical College of Georgia Foundation, Inc., which provides scholarships, research grants and special grants for professors and instructors.

Second District

The old Tift County Hospital has been named the Pickett Building in honor of the late **Dr. Frank B. Pickett**, former MAG member who died in 1968 and who had practiced medicine in the county for 50 years.

Third District

Morton P. Berenson, Columbus, has recently returned from a hiking trip along the Appalachian Trail. He covered the Great Smokey Mountain National Park from its western to eastern ends, a distance of 72 miles. He entered the trail at Fontana Dam and hiked north to I-40.

Radiologist **Wayne Bohannon**, a 1963 graduate of the Medical College of Georgia, is moving his practice to Eastman joining the staff of the Dodge County Hospital.

C. Daniel Cabaniss, Columbus, is one of 315 physicians across the United States recently made a Fellow of the American College of Physicians.

Micki L. Souma, chief Department OB-GYN, and **Richard E. Thompson**, chief Department of Pediatrics of The Medical Center in Columbus have opened a March of Dimes Genetic Counseling Service held the first Saturday of each month. **Paul G. McDonough** from the Medical College of Georgia and **Louis Elsas** from Emory are consultants.

Dave Varner and **Jim Venable** have moved their offices from the Medical Arts Building to the new professional Complex at St. Francis Medical Park in Columbus.

Fifth District

Three Atlanta doctors have been named new Fellows of The American College of Physicians: **Arnoldo Fiedotin**, **John M. McCoy** and **Donald O. Nutter**.

Winners of the first annual Doctors' Double Tennis Tournament in Muscogee County, Walker Harris (L) and George Lipscomb challenge other societies to sponsor doubles teams.



ASSOCIATION PAGE / Continued

Armand A. De La Perriere of Atlanta has been installed as a Fellow of the American College of Obstetricians and Gynecologists at its 21st Annual Meeting in Miami Beach in May.

The newly-established post of vice president for Emory University's Woodruff Medical Center has been filled by **E. Garland Herndon, Jr.**, a faculty member since 1958. Dr. Herndon now serves as associate dean of the medical school and medical director for Emory University Hospital. His new position is effective Sept. 1, 1973.

Garland D. Perdue, Jr., associate professor of Surgery and head of the Peripheral Vascular Surgery for Emory University, served as "Dialogue" authority for an exhibit, "Management of Post-Surgical Infection" created by Pfizer Laboratories. The exhibit was shown during the AMA annual convention in New York at the end of June.

Lovic W. Hobby and **Milton S. Goldman** were inducted at the San Francisco Clinical Congress into the American College of Surgeons; **W. Nisbet Toole** and **Joseph J. Nichols** became Fellows of the ACS at the same meeting.

Ninth District

Ralph Bottoms, Cumming, has been selected for mention in the 1973-1974 *Who's Who in the South and Southwest*. Dr. Bottoms was the oldest person to graduate in the 145 year history of the Medical College of Georgia when he completed work in 1959 at the age of 45. He had served earlier as a school teacher, industrial engineer and minister.

Tenth District

John R. Palmer has been appointed chairman of the new Department of Physician's Assistants in the School of Allied Health Sciences, Medical College of Georgia in Augusta. Dr. Palmer also holds the positions of associate professor in the department and associate professor of Family Practice in the Department of Medicine.

DEATHS

Thomas Harrold

Past president of the Bibb County Medical Society, Thomas Harrold, died at his home in Macon May 29 after a long illness. He was 75.

Born in Americus, Dr. Harrold was graduated from the University of Georgia and Johns Hopkins University School of Medicine. Following graduation, he served in the U.S. Army during World War I.

He was a member of the American Red Cross board of directors, elected to the board of Citizens and Southern National Bank and served on the board of advisors to the Booker T. Washington Community Center.

For many years Dr. Harrold served as head of the Macon Tumor Clinic. He was a member of the Southern Surgical Association and a Fellow in the American College of Surgeons.

Survivors include his widow, the former Silvine Mar-

bury of Baltimore, Md.; three daughters, Mrs. Carl Hudson of Memphis, Tenn., Dr. Frances Harrold of Atlanta and Mrs. William C. Thomas of Richmond, Va.; sister, Mrs. Frank Sheffield of Atlanta; six grandchildren.

Francis Clifford Nesbit

Francis Clifford Nesbit, Covington, head of the Newton County Alcoholic Clinic and former president of the Newton-Rockdale Medical Society, died of cancer May 10 at the age of 82.

Dr. Nesbit had been a member of the Medical Association of Georgia more than 50 years. He served as the Newton County surgeon for Southern & Central of Georgia Railroad and was on the executive board of Newton County Hospital.

A native of Norcross, Dr. Nesbit was graduated in 1912 from Atlanta School of Medicine, now Emory University, and interned in several New York City hospitals. His postgraduate work in urology was completed at New York Polyclinic.

Dr. Nesbit practiced in Waycross prior to World War I, then in Atlanta before moving to Covington in 1941 where he was a member of the Covington Rotary Club. He was also a Mason and a member of the Atlanta Elks Club.

Survivors include his widow, Mrs. Anne Nolan Nesbit; son, Nolan Nesbit of Stone Mountain; brothers, Noye Nesbit, Maurice Nesbit, Raymond Nesbit and Curtis Nesbit of Norcross and Grayle Nesbit of Tampa, Fla.; two grandchildren.

LEARN TO KEEP A CAPTIVE AUDIENCE CAPTIVATED

A Speech and Leadership Seminar designed to instruct those attending on how to organize a speech and analyze an audience will be offered September 8 and 9, 1973 at the Macon Hilton. The Seminar is open to doctors, their wives and employees and will allow participants to take an active part in creating and delivering short speeches.

Directors of the seminar will be Robert A. Lang, executive secretary of the Academy of Medicine in Cleveland, Ohio and T. Stephen May, associate professor at the School of Speech, Northwestern University, Illinois.

For registration or additional information, contact Dr. B. B. Sanders, Jr., 700 Spring Street, Macon, Georgia 31201.

THE MONTH IN WASHINGTON

Strong protests from the American Medical Association and others have led the Secretary of the Department of Health, Education, and Welfare to hold letters from Social Security's Bureau of Health Insurance that ordered Medicare and Medicaid intermediaries to augment hospital utilization review by requiring a pre-admission certification program, and the use of national, regional or other appropriate data on length of stay by diagnosis to establish extended-stay cut-off dates.

In letters and visits with HEW Secretary Caspar W. Weinberger, AMA board chairman, John R. Kernodle, M.D., urged that "... The Social Security directive be reviewed, not only from the standpoint of its validity under the Medicare law, but also with respect to its apparent preemption of functions given by the Congress to Professional Standards Review Organizations (PSRO).

"... We believe the purpose of an intermediary letter should be limited to administrative matters affecting carriers. If providers of service are affected we believe that any changes should be the subject of proposed regulations under which the providers and the carriers are given an opportunity to present their views. In the case of the intermediary letters under consideration, we question their validity and appropriateness at this time. We believe that they should not be issued at this time and that they would more appropriately be included in the PSRO regulations."

Social Security stated that the proposed new instructions in its intermediary letters "are intended to be supportive of the PSRO effort."

Public Concern

The reason for the new procedures, according to Social Security, is "increasing public concern at all levels over the need for more effective utilization of health care while maintaining or improving the quality of care rendered."

Social Security describes the new instructions as "processes that are to be employed for the period prior to the emergence of PSROs. Hospitals will require that the attending physician present appropriate documentation for use by the UR committee, or its representative, for approval of the hospital admission prior to—or at the time of—elective admissions, and within one working day subsequent to emergency or urgent admissions.

"A representative of the utilization review committee will review all applications for admission of Medicare beneficiaries; however, not all would be reviewed in the same depth. By employing a selection technique found appropriate by SSA, the utilization review committee will subject an appropriate number of the applications for admission to close, professional scrutiny. For example, the utilization review committee will be required to review intensively all questionable admissions (i.e., those involving questionable diagnosis, and treatments, for which close review is appropriate because

of high cost, frequency of abuse, or propensity for potential misutilization)."

"All admissions approved by the utilization review committee will be certified by the committee for a specific duration based on appropriate percentile or past data (or other data acceptable to the Secretary). Where the committee does not approve the admission, the attending physician and the beneficiary are to be notified immediately, i.e., within 24 hours. Reviews of admissions are to be scheduled prior to or at the time of the expiration of the initial projected length-of-stay and in subsequent additional stays where the attending physician recommends and the utilization review committee approves continuing hospitalization. Appeal rights are to be provided to protect the beneficiary, hospital, and the attending physician from improper denials.

"The proposed new procedure calls not only for a change in timing of review but for analysis of utilization review findings and the correction of problems that are identified. . . ."

Social Security said the intermediaries would conduct on-site reviews to "verify that pre-admission certifications and subsequent reviews are made timely and conscientiously." Carriers would be required to exchange information to identify "potentially aberrant patterns of service and to take appropriate corrective action."

Statewide PSROs

Some 150 physicians representing 38 state medical associations and foundations have visited congressmen and federal officials to make a case that statewide PSRO coordinating systems should be permitted when the program is implemented.

The government has indicated that statewide PSROs are likely only in very small states though the law contains no such restriction. Chief congressional sponsor of PSRO, Senator Wallace Bennett (R.—Utah) insists the intent of the law is to bar statewide setups in large states.

PSRO is the provision of last year's Medicare-Medicaid amendments that calls for a structured professional review system for Medicare and Medicaid which will review initially all institutional care and later all care, including private physicians' care.

Most of the lawmakers visited expressed sympathy for the position of the state groups and said they would transmit the concern to HEW. At a follow-up meeting HEW officials, however, indicated no change in policy is planned at this time.

Henry Simmons, M.D., Deputy Assistant Secretary for Health, said: "It appears clear that statewide PSROs would be difficult to square with congressional intent." The legislative history of the provision, Dr. Simmons added, "makes plain" that there should be a number of PSROs in the larger states.

However, state and AMA representatives argued that there should be some arrangement under which a state-

wide umbrella organization can be part of the PSRO program, and that medicine desired a condition under which those state organizations which are interested and qualified could participate in a management role in the PSRO program in their states.

PSRO Director William Bauer, M.D., told the state representatives that final area designations won't be made until November at the earliest and that "states with a significantly large number of physicians can be expected to have more than one PSRO." Dr. Bauer stressed, however, that he will be as flexible as possible in operating the program.

In the exchange of communications between the HEW Secretary and AMA officials, two other stands of organized medicine were made abundantly clear.

Current Procedural Terminology

Dr. Kernodle in a letter to the Secretary took issue with Social Security's opposition to current procedural terminology (CPT) as a coding system for carriers. Dr. Kernodle said the AMA has spent many years and hundreds of thousands of dollars in developing "what we think is the finest and most complete description of medical and surgical procedures that is possible."

Dr. Kernodle pointed out that the physicians of at least six states and the carriers operating in these states wish and stand ready to put CPT into operation. But Social Security continues to prohibit this on grounds that it might raise costs. Actually, Dr. Kernodle said, studies indicate that costs increases would be minimal at most and at least one state has found the use of CPT reduced costs.

"All the American Medical Association is asking is that those carriers who wish to use CPT be granted the opportunity."

In the same letter to the HEW Secretary, Dr. Kernodle wrote: "... The final and most important point we wish to make (and one that is at the core of many other areas of concern) is our firm belief that medical and health matters currently under the jurisdiction of the Social Security Administration and the Social and Rehabilitation Service should be under the jurisdiction of the Office of the Assistant Secretary of Health."

Reduced HMO Bill

The Senate has approved a drastically reduced Health Maintenance Organization bill (69-25) after liberal forces led by Senator Edward Kennedy (D.—Mass.) fell back in retreat.

The measure that finally emerged after two days of debate called for spending \$805 million over three years to encourage development of pre-paid group practices or contract practice-type organizations. Last year, the Senate overwhelmingly voted a \$5.1 billion HMO program.

The legislation now goes to the House where a House health subcommittee has approved a \$280 million program. The Senate has been warned that any bill far exceeding the Administration's request for an experimental, \$60 million first-year plan may face a Presidential veto.

Confronted by surprisingly strong conservative opposition to the \$1.5 billion scale of the HMO bill reported

by the Senate Labor and Public Welfare Committee, Kennedy was compelled to capitulate twice on the Senate floor. He first proposed a \$865 million substitute that would have relaxed many provisions of the original measure. At the end he switched support, successfully, to a Republican substitute introduced by Sens. Jacob Javits (R.—N.Y.) and Richard Schweiker (R.—Pa.).

The Javits-Schweiker bill authorized \$705 million. Added to this by the Senate was a \$100 million provision by Sen. William Hathaway (D.—Maine) to foster HMO development in rural areas.

Kennedy said the revised bill would fund about 200 HMOs "which have been proven to work."

The bill adopted by the House Health Subcommittee several days before the Senate vote would aid about 100 HMOs at a cost of some \$280 million over three years. This bill still must be voted on by the House Commerce Committee and the House.

Criticizing the original HMO bill, Sen. Robert Taft, Jr. (R.—Ohio) said the Senate would be "unwise to propagate by legislation a remedy for health care which has not yet passed any of the necessary tests. Before we even have a chance to get the test models off the ground, it is now proposed to fly with a whole fleet of HMOs."

Medical Malpractice

The creation of a new Joint Commission on Medical Malpractice is being planned by major medical organizations as a means of curbing the rising number of damage claims and controlling health care costs.

Joining in the new venture would be the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and representatives of medical specialty societies.

The plan was discussed by John R. Kernodle, M.D., Burlington, N.C., chairman of the AMA Board of Trustees, in a speech before the American College of Obstetricians and Gynecologists meeting in Bal Harbour, Fla.

"While the AMA has been active in the commission's formation," Dr. Kernodle said, "we are fully aware that it is only through joint action that the malpractice issue can be met."

"The commission will gather and disseminate information on the nature, frequency, costs, and causes of malpractice claims . . . and recommend equitable and appropriate ways of minimizing the claims problem."

Budget Cuts

John A. D. Cooper, president of the Association of American Medical Colleges, has blasted the Nixon Administration's proposed budget cuts for fiscal year 1974, saying they present a serious financial blow to medical education, bio-medical research, and health care.

"Without advance warning and apparently without any real understanding of the consequences of their decision," Dr. Cooper said, "the Administration is seeking to terminate support for research training, Community Mental Health Centers, Hill-Burton hospital construction, the Regional Medical Program, and capitation support for schools of Veterinary Medicine, Pharmacy, Optometry and Podiatry. In nearly all other areas of the proposed budget, the President is asking the Congress to curtail or cutback federal monies for health."

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41. MICROBIOLOGY A. CULTURES	Blood	Urine	Throat Sputum	Wnd Skin	Tis. Ear	Nasal	Stool	Other	B. SMEARS Sputum	Genit. Urethr.	Other	42. HISTOLOGY Cervical Pap	Other Cytol	Frozen Section	Other		
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43. BLOOD CHEMISTRY SMA 12	Electrolytes	Enzymes	Blood Gases	Nitrog. Cmpds.	Minerals	Proteins	Lipids	Liver Funct.	GLUCOSE Fasting	PPBS GTT	Random	Other	44. URINE TESTS Urin- alysis	Spec. Urine	Fract.		
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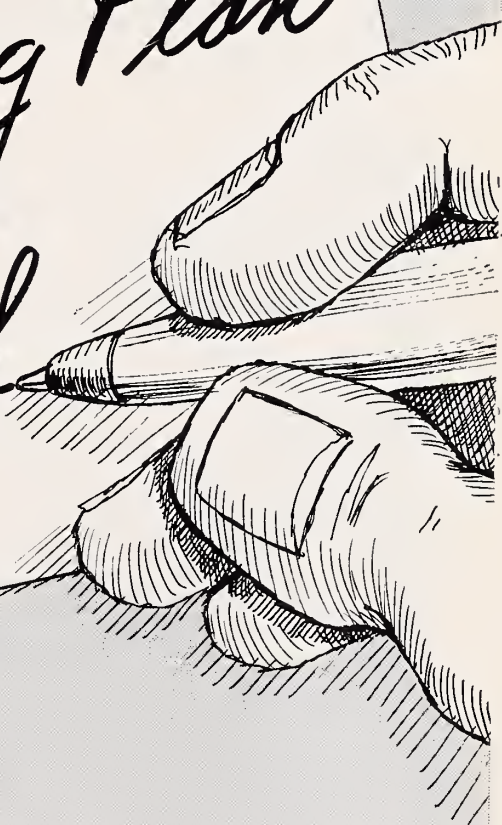
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Cover

Sample of a hospital discharge abstract, one step in EMCRO's computerized review system. Layout by Atlanta artist Bob Hamill.

A pregnancy testing model is presented which can help gain entree to the local community.

In-Hospital Family Planning An Approach to Rural Maternal Health Care

EDWIN S. BRONSTEIN, M.D., M.P.H., *Augusta**

MANY PROBLEMS EXIST in the delivery of maternal health care in rural areas. Lack of patient access and the unavailability of such services are among the factors contributing to the high infant mortality and perinatal mortality that exists in some rural areas in Georgia. Infant mortality in some rural counties reach levels of 40 per thousand live births.¹ The post neonatal mortality rate continues to be 40 to 50 per cent of all infant deaths in these areas. These figures may be twice the levels of infant mortality rates locally and nationally where access to health care may be more adequate.

It has long been known that among programs of maternal health, family planning has the best cost/benefit ratio.² Family planning programs have been existent in Georgia since 1939. Modern medical services in family planning were brought to the state with the Family Planning Act of 1968.³ In an attempt to reach the more than 200,000 estimated eligible indigent females in need of family planning services throughout the state, special programs in family planning had been established through the State Health Department and through special grants for programs in a limited number of Georgia communities. At the present time,⁴ about 30 per cent of the estimated eligible indigent population in need has been reached. Governor Jimmy Carter,⁵ in an executive order, has asked that a voluntary family planning program be established for all the people of

Georgia. He has established a special council to implement this task.

Changing Attitudes

One of the major needs in large segments of the community is education and a change of attitudes and behavior in family planning. In each community there are gatekeepers; key individuals who can carry the message of family planning in their own community. These individuals have often been patients at a local hospital or health center or are employed in that hospital or health center. This group should be excellent change agents in family planning for the community in which they live. Each hospital in the state is a good entree for patients into a comprehensive family planning program.

In Richmond County, the health industry is the leading employer. Of the 64,000 people listed as employed by the local labor department, approximately 16 per cent are employed in the health industry in Richmond County.⁶ Of those employed, 23 per cent are females. At the Medical College of Georgia there are approximately 3,500 employees. There are also patients on services other than obstetrics and gynecology who are in need of family planning services, both as in-patients and as out-patients. In order to determine the desirability of an In-Hospital Family Planning Program, a questionnaire was sent to each of 3,500 employees. This paper reports on the results of that questionnaire and describes a model for pregnancy testing which can be used in hospitals and

* From the Section of Maternal Health and Family Planning, Department of Obstetrics and Gynecology, Medical College of Georgia.

other health facilities as an entree for people to get into a family planning program.

Materials and Methods

A questionnaire was sent to 3,500 employees at the Medical College of Georgia. Accompanying the questionnaire was a description of an In-Hospital Family Planning Program which included services currently being offered at the Talmadge Hospital, as well as additional proposed services. The list of these services, such as pregnancy testing, methods of birth control, genetic counselling, infertility services, sterilization, abortion, prenatal care and inter-conceptional care, was accompanied by a brief and simple statement describing each service. The respondents were then asked questions about the utilization of such services.

Results: Five hundred eleven responses were received (16.5 per cent). The response of employees was predominantly from secretaries, research assistants, students and faculty members. There was a lack of response from those of poor and marginal incomes, many of whom lack access to adequate health care and may be in need of family planning services. The average age of the female respondent was 29.9 years and that of the male 30.4 years. The consensus of opinion, both male (62.5 per cent) and female (57.6 per cent) was that a program of In-Hospital Family Planning would be welcomed and used by the majority of respondents. At the present time 90 per cent of all respondents do make use of family planning services. Twenty-six per cent of all respondents had an unplanned pregnancy. Of the respondents who felt that they would not use such a facility, 25 per cent have had some form of sterilization procedure, either the male or female of the couple.

Pregnancy Testing Model: A pregnancy testing model with a small counselling service can be effectively used in a local hospital or health facility as a method of entree into a family planning program for patients in rural communities. A counsellor, trained in family planning, who has knowledge of the available resources in a community and can perform pregnancy tests is all that is needed—depending on the size of the community. Through the use of the local mass media, as well as notification of physicians and other health personnel in a community, women can be reached through the following statements:

1. Missed a period? Concerned you're pregnant? Come in and be tested.

2. Do you suspect pregnancy? Come in and find out.
3. Period late? Concerned? Check for pregnancy.

When an individual comes to the family planning counsellor, one question is asked, "If you are found to be pregnant, is this pregnancy a wanted pregnancy?" Each patient then has a pregnancy test which can be done rapidly. As a result of the pregnancy test and the response to the question of a wanted or unwanted pregnancy, the patient can be placed into one of four categories as seen in Figure 1. In the first

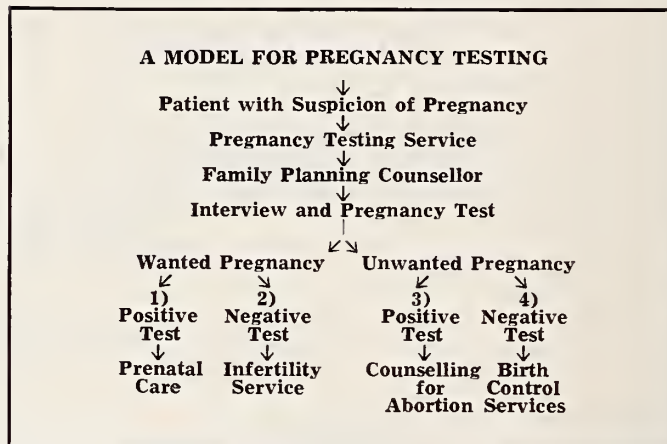


FIGURE 1

category, the patient wants the pregnancy and has a positive pregnancy test. She can be referred for early prenatal care. This serves as an entree into the maternal health care system of early and adequate prenatal care.

In the second category, the patient desires the pregnancy but the test is negative. If the patient has been trying to get pregnant for a period of more than a year, she can be referred for infertility services. This should be a part of the overall family planning services and if these services are unavailable in the local community, a referral to a larger center can be made.

In the third category, the patient does not desire a pregnancy and the pregnancy test is positive. This patient can be counselled as to whether or not she would desire an abortion or if she needs additional support to have the baby and give the child up for adoption, or to make the final decision and keep the baby. If she chooses to interrupt the pregnancy, this can be determined early so the patient can be referred for abortion. The morbidity with suction curettage in early pregnancy is notably lower than that found with saline instillation in pregnancies of more than 12 weeks gestation.

In the fourth category, the patient does not desire a pregnancy, and the pregnancy test is negative. This patient can be referred for contraceptive services using modern methods of birth control. Other indi-

viduals in the community may also use this service, not as a pregnancy testing service, but as a means of entree into family planning programs for the utilization of services such as sterilization by vasectomy or tubal ligation.

This model of Pregnancy Testing and Family Planning Counselling can be used in rural communities. For those services that are not available, appropriate resources can be defined at regional centers whereby patients can be referred so that the model can be carried to completion.

Innovative Approaches

It is through innovative approaches that health care programs such as family planning can be delivered more effectively in rural communities. It is imperative that in such programs a good system of follow-up be built into the pregnancy testing model. Whenever a patient is referred, adequate information should be sought as to the eventual outcome.

Using a pregnancy testing model as an entree, people in the local community, as well as those in a hospital can make use of family planning services. When family planning services are available through an In-Hospital Family Planning Program, patients on services other than obstetrics and gynecology should also have access to family planning methods. There should be provision for post partum patients to have adequate counselling and family planning services upon discharge from the hospital. Patients who are post abortal or those having other gynecological problems who are also in need of family planning services should have them provided. Patients on services such as medicine, surgery, pediatrics, should also have the availability of family planning counselling and the provision of adequate methods of contraception wherever necessary. The wife of a victim of cancer who becomes pregnant with an unwanted pregnancy need not have to suffer the emotional trauma. The awareness and the provision of family planning services to all patients in the hospital can overcome and prevent the occurrence of such situation.

The hospital can also become, through its employees, a gatekeeper into the community at large for the diffusion of family planning information and practices as well as the vehicle for the behavioral changes and attitudes that need to be brought about in

a rural community in order to have effective family planning.

Hospitals in Georgia have expressed a desire to participate in the Statewide Family Planning Program.⁷ Of 168 questionnaires sent by the Governor's Council, 126 responded. At least 30 hospitals presently have no services but wish to develop them.

Summary

The results of a questionnaire for an in-hospital program in family planning have been described. Sixty-five per cent of the respondents were in favor of family planning services being provided in the hospital environment. Ninety per cent of the respondents were currently using a method of family planning and 25 per cent have described an unplanned pregnancy at some time in their past. Of those respondents who were not supportive of such a program, 25 per cent already had sterilizing procedures.

A greater response is needed from the poor and marginal income workers in the hospital. The hospital is an important site of providing family planning services. This should be done on the post-partum and gynecology floors as well as on pediatrics, surgery and medicine. Patients with problems may be in need of contraceptive services.

A model for pregnancy testing utilizing a family planning counsellor and a pregnancy testing service has been described. This model can be used in rural communities, at hospitals, and health departments as an entree into maternal health care services.

I wish to acknowledge the assistance of Miss Valerie King, Mr. Richard Gillock, Administrator of Talmadge Hospital and Dr. Robert Reynolds, Associate Dean for Health Care Programs.

Medical College of Georgia 30902

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Hematuria and a Filling Defect in the Renal Pelvis

W. C. LANG, JR., M.D. and RICHARD STEELE, M.D., *Atlanta**

DR. W. C. LANG: This is a case of a 49-year-old male with painless hematuria. An intravenous urogram was performed as the initial study in this patient. Dr. Steele, would you comment on the pyelogram?

Dr. Richard Steele: The pertinent finding on the intravenous pyelogram is a filling defect in the pelvis of the right kidney (Figure 1). The cortex of the right kidney appears smooth and there is no abnormality of the minor calyceal system.

Dr. Lang: A retrograde pyelogram study was done as the next procedure. What do you think of these films?

Dr. Steele: The filling defect in the renal pelvis is again seen and appears unchanged from the preceding intravenous pyelogram. The filling defect does not appear to change in position on the multiple films.

The things to consider when a filling defect is demonstrated in the renal pelvis, such as we see here, are a radiolucent stone, such as urate or cystine stone, and a blood clot since the patient had a history of hematuria, in both of these abnormalities one would expect to see some change on multiple films. We don't see any evidence of change here. Inflammatory lesions would seem unlikely, fungus balls have been described in the upper urinary collecting system, they do not have the appearance presented here. Tuberculosis can cause some irregularity secondary to granulation and contracture of the pelvis, there are no abnormalities of the cortex, minor calyces or ureter which would be associated with urinary tract tuberculosis. The most likely possibility appears to be neoplasm, such as transitional cell carcinoma of the renal pelvis or, less likely, clear

cell carcinoma of the kidneys which has invaded into the renal pelvis.

Dr. Lang: Following the retrograde pyelogram, an angiogram was performed.

Dr. Steele: I suppose that the angiogram was performed because of the possibility of clear cell carcinoma invading the renal pelvis. The angiogram shows no evidence of tumor stain or abnormal vascularity to suggest carcinoma. There is no marked displacement of vessels to indicate renal mass. A



FIGURE 1

Pyelogram of the right kidney demonstrating multinodular filling defect within the renal pelvis indicated by the arrows.

* From a weekly X-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements, Jr. and H. S. Weens.

transitional cell carcinoma would be an avascular lesion and these angiographic findings would be expected. My first choice would be that this lesion represents transitional cell carcinoma.

Dr. H. S. Weens: You attach significance to the fact that the mass lesion does not change on the multiple films. Unless special attempts were made to displace blood clots or stones by gravity it is doubtful that there would be any change on the multiple films which were all produced with the patient in the supine position. How long do you think that it would take a blood clot to resolve?

Dr. Steele: I should think that there should be some change observed over a four or five day period.

Dr. Weens: Blood clots can persist for several weeks with little change and can result in considerable confusion and lead to an erroneous diagnosis of tumor.

Dr. Lang: The diagnosis is quite correct. The patient had transitional cell carcinoma of the renal pelvis and underwent nephrectomy. At surgery there was no evidence of seeding of the neoplasm to the ureter. The gross specimen demonstrates the multilobular fungating lesion, filling the renal pelvis and correlating well with the radiographic findings (Figure 2). Histologically, this was transitional cell carcinoma.



FIGURE 2

Photograph of the gross specimen. The renal pelvis has been opened demonstrating the multilobulated transitional cell carcinoma.

Comment

Transitional cell carcinoma is by a large margin the most common malignant tumor of the renal pelvis and ureter. This is primarily a disease of males in a four to one preponderance over females. Eighty to 85 per cent of these tumors are papillary, 40 per cent of which are infiltrating. The non-papillary tumors tend to be more infiltrative and malignant, more than 40 per cent of the papillary tumors are multiple. The solitary tumors are most frequently found in the renal pelvis. When multiple tumors are present, the renal pelvic tumor is generally considered the primary, with the ureteral tumors generally considered implants. For this reason, whenever a tumor is found anywhere in the urinary tract, the entire tract must be visualized to be certain no other lesions are present. Multiple tumors are nearly always on the same side, but bilateral tumors have been reported.

The classic symptomatology are flank pain, gross hematuria and mass. The pain is generally secondary to obstruction, not infrequently associated with a stone above the lesion, so that tumor must not be overlooked in the presence of a stone.

Radiographically, the finding of hydronephrosis in a male over age 40 should be highly suspect of epithelial tumor. Negative filling defects in a hydronephrotic kidney with hematuria could be clots or tumor, although the pathognomonic finding is a lucent filling defect in a relatively normal renal pelvis.

When filling defects are found in such a clinical setting, the differential should include blood clot, non-opaque calculi, and parenchymal renal tumor which has invaded the renal pelvis. When the tumor is in the ureter, the classic sign is dilatation of the ureter above and below the tumor site in contradistinction to a stone, in which the ureter distal to the filling defect is not dilated. This finding is usually better seen on retrograde.

Nonpapillary tumors are much more difficult to visualize, but when large will present as a smooth-contoured negative filling defect. All apparent ureteral strictures in a patient of cancer age should be highly suspect.

Emory University 30322

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EMCRO's hospital discharge system may allow the hospital to conduct its own review in lieu of PSRO scrutiny of individual claims.

EMCRO: The Hospital

LOWELL A. FOSTER and SYBIL B. WELLS, *Atlanta**

IN 1971, THE COUNCIL of the Medical Association of Georgia, in order to preempt the imposition of national standards for quality of medical care through impending PSRO legislation, sought funds to support the development by Georgia physicians of alternative means of review of medical care. In June of that year, MAG received the first of three years of funding for that purpose from the National Center for Health Services Research and Development. The Experimental Medical Care Review Organization (EMCRO) program was the source of these funds.

The EMCRO program of the Medical Association of Georgia has developed two review systems, now being field tested. The Hospital Discharge Abstract System is described in this article; the Nursing Home Abstract System will be described in a future article.

The Hospital Discharge Abstract System is designed to meet audit and statistical requirements of the Joint Commission on the Accreditation of Hospitals and other accrediting agencies. It serves as the basis for an in-house system of medical review. Such a review system, if seen as effective by the Professional Standards Review Organization (PSRO), may allow the hospital to conduct its own review in lieu of PSRO scrutiny of individual claims.

Screening Parameters

To assist the Medical Audit and Utilization Review Committees of a medical staff in performing their review, screening parameters have been developed to identify the pattern of care expected. To date, the following state specialty societies have developed parameters of care for 100 common diagnoses and surgical procedures: Dermatology, Family Practice, General Surgery, Internal Medicine, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pediatrics, Psychiatry and Urology. Five to seven physicians

were selected by the presidents of each of these specialty societies to form the panels which developed these parameters. The Interspecialty Council coordinated the meetings of those specialty panels.

The parameters were developed by the specialty panels using a worksheet developed by EMCRO. The worksheet lists by category the most significant and frequently performed services—both diagnostic and therapeutic. The panels indicate which of these services are “critical to high quality care” or “consistent with the diagnosis.” “Critical” services are those which, generally speaking, should be provided to essentially all patients admitted for treatment of the given diagnosis. “Consistent” services are those which should occasionally be provided to patients admitted for treatment of the given diagnosis. Services which should only very infrequently be provided or which should have documented justification are generally not included as “consistent” services. The panels feel that medical staff review of these services is desirable. Parameters for length of stay and for contraindicated services are also developed. In addition, as an aid to the Utilization Review Committee, indications for admission are provided. However, these indications are not collected or reviewed by the EMCRO Hospital Discharge Abstract System.

The parameters will be modified by the specialty panels in November as they review the results of the field test. The medical staff of hospitals participating in the field test will have input to the modification of these parameters, based on the experience within their hospitals. The modified parameters, as well as newly developed parameters for additional diagnoses, will become part of the EMCRO Hospital Discharge Abstract System in January of 1974.

Hospital Discharge Abstract System

Within hospitals, a systematic study of care is provided through medical staff committees such as the Medical Audit Committee and the Utilization Re-

* Mr. Foster serves as EMCRO director and Sybil Wells as associate director.

- I. INDICATIONS FOR ADMISSION *
- Pap smear Class III, IV or V
 - Positive biopsies
 - Ulceration of cervix with bleeding
 - Evaluation for recurrence

SCREENING PARAMETERS

- | | |
|--|--|
| <p>II. INVESTIGATIVE PROCEDURES CRITICAL TO HIGH QUALITY CARE</p> <ol style="list-style-type: none"> Hematology
CBC Urinalysis <p>III. MANAGEMENT CRITICAL TO HIGH QUALITY CARE</p> <p>Surgery and Other Procedures
Conization of cervix or multiple cervical biopsies or fractional curettage **</p> <p>IV. INVESTIGATIVE PROCEDURES CONSISTENT WITH THIS DIAGNOSIS</p> <ol style="list-style-type: none"> Hematology
CBC
Hemoglobin
Hematocrit
Blood type, Rh, crossmatch Blood Chemistry
Multichannel chemistry (SMA₁₂)
Electrolytes
Serum enzymes
Nitrogenous compounds
Minerals
Serum proteins
Lipids
Liver function tests
Glucose
Fasting
Random Serology
Serological tests for syphilis Endocrine and Hormone Studies
Ovaries
Pregnancy test * Microbiology
Urine culture and sensitivity Histology
Pap smear Radiology
Barium enema
Chest
IVP **
Retrograde pyelogram **
Skeletal survey for metastasis
Venography **
Lymphangiogram ** Nuclear Medicine
Liver scan
Isotope studies
Blood volume * Miscellaneous Tests
EKG | <p>V. MANAGEMENT CONSISTENT WITH THIS DIAGNOSIS</p> <ol style="list-style-type: none"> Drugs
Antibiotics
Other anti-infectives
Anti-neoplastics
Radioactive therapeutics
Narcotics
Barbiturates and hypnotics
Non-narcotic analgesics Parenteral Fluids/Blood
Hydrating and caloric agents
Electrolytes
Whole blood
Packed red cells
Plasma, blood derivatives Other Therapy
X-ray or super voltage therapy (internal and/or external radiation therapy) Surgery and Other Procedures
D & C **
Cervical biopsy **
Conization of cervix **
Hysterectomy **
Radical hysterectomy with or without lymph node dissection **
Ultra-radical surgery **
Sigmoidoscopy **
Cystoscopy ** Consultations
Radiotherapist **
Gynecology **
General Surgery **
Urology **
Thoracic **
Neurosurgery **
Orthopedic **
Internal Medicine ** <p>VI. SUGGESTED LENGTH OF STAY</p> <ol style="list-style-type: none"> D & C with conization of cervix:
2 - 4 days D & C with pathology report and internal radiation therapy:
5 - 8 days Hysterectomy: 5 - 8 days Radical hysterectomy with or without lymph node dissection:
8 - 21 days |
|--|--|

* Not included on Abstract
** Coded on Abstract

FIGURE 1

Screening parameters for carcinoma of the cervix developed by the OB-GYN Specialty Panel.

view Committee. To be effective, these committees must maintain objectivity as well as have adequate means of review available. With this in mind, the EMCRO Hospital Discharge Abstract System incorporates a series of medical staff reports. These monthly reports are generated through a computerized data processing system by which the screening parameters are compared to the care reported on the medical record.

The monthly Medical Audit Exception Report describes only those cases which deviate from the screening parameters specified by the specialty panels. On this report, deviations from the following will be indicated:

- (1) Patients not receiving services considered critical to the care of the principal diagnosis;
- (2) Patients receiving services which are not consistent with any diagnosis for which screening parameters have been established; and
- (3) Patients receiving services contraindicated for any diagnosis for which screening parameters have been established.

Consideration of only the exceptions reduces physician review time. Since exceptions do not report the total care provided, percentages of patients receiving each diagnostic service or therapeutic procedure will be displayed. This allows a committee to assess patterns of care and identify emerging methods of treatment. As physician identity is coded, objectivity is maintained throughout the review process.

The Utilization Review Report indicates, by service, the percentages of patients receiving diagnostic or therapeutic procedures in excess of those indicated by the screening parameters. After viewing these patterns, the committee can identify specific cases for review through the Medical Audit Exception Report. Pertinent information is provided on these reports, allowing the committee to make their determination of appropriateness, etc. The medical record department receives JCAH-required indexes and statistical reports. In addition, the hospital administrator is provided with management reports which facilitate hospital decision making.

The contribution of the medical record depart-

ment to the process of evaluation of quality of care is significant. The quality of the medical record is a cooperative effort of physicians and the department. Time must be spent to abstract data from the record of each discharged patient. While completion of the abstract does not require that the abstractor make judgements, the quality of data is dependent on her interest and knowledge as well as the quality of the medical record. The EMCRO staff provides instruction on the coding and abstracting of data for personnel of participating hospitals. In addition, training

in the analysis of data for a health record analyst in the hospital will assure effective use of reports by the medical staff committees. The health record analyst will assist in identifying data of interest in reports, or retrieve information for such studies as the Medical Audit/Utilization Review Committees may specify.

Thus, through its provision of useful data in manageable report form and with the assistance of trained personnel, the EMCRO Hospital Discharge Abstract System aids the medical staff in its conduct of effective review through the functioning of that medical staff's own committees.

938 Peachtree Street, N.E. 30309

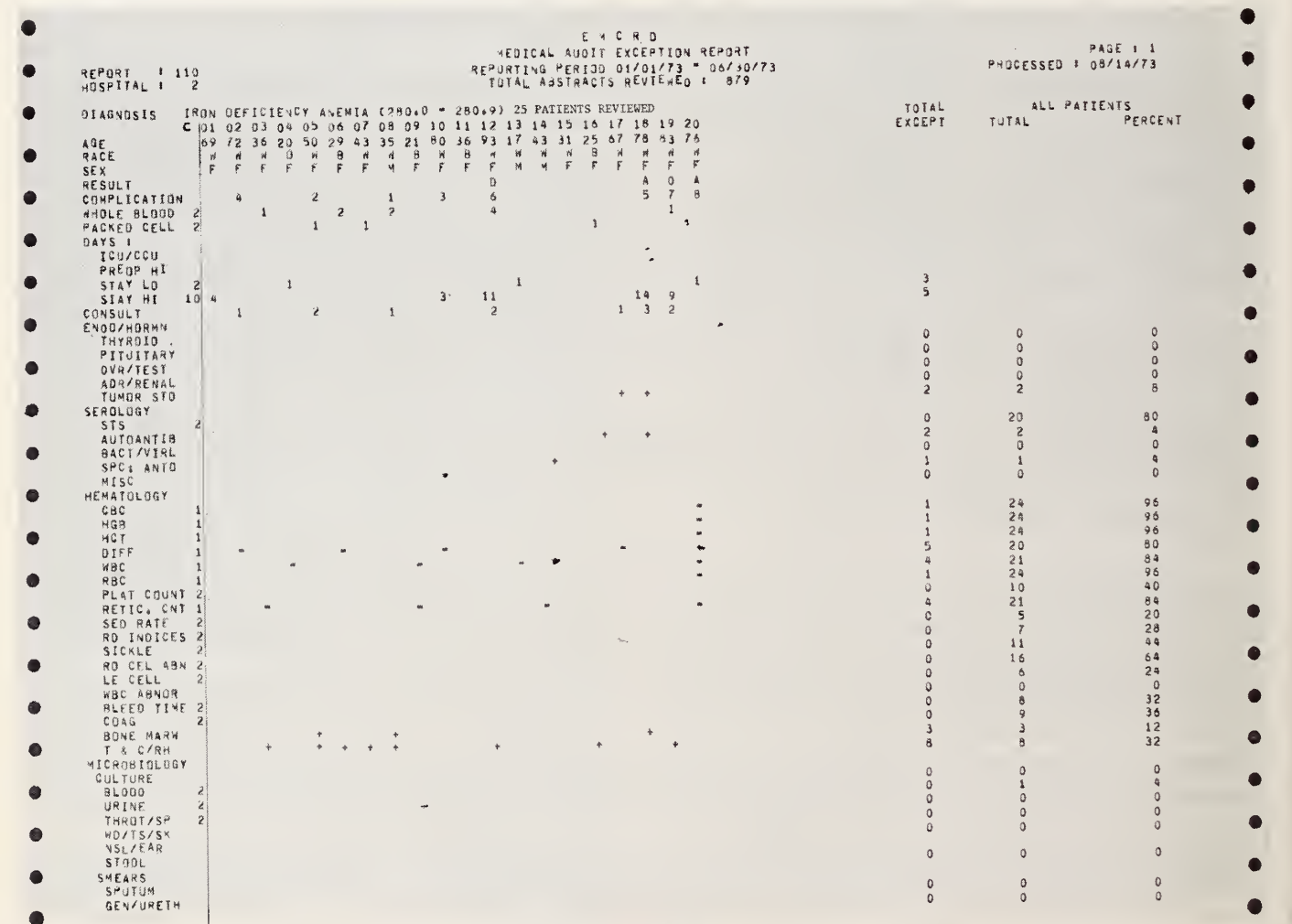


FIGURE 2

First page of the Medical Audit Exception Report indicating exceptions to the screening parameters for iron deficiency anemia.

Ready accessibility of high quality care to any patient in Georgia is one of the goals of this system now being planned in detail.

A Georgia Cancer Management Network

CHARLES M. HUGULEY, JR., M.D., *Atlanta*

THE COMMITTEE ON CANCER of the Medical Association of Georgia, with the approval of the council, is working toward the development of a statewide cancer control program. Briefly, this control program or network would preserve intact and build on the achievements of the Georgia Regional Medical Program to insure that the best possible care for cancer is available to patients throughout the state.

We in Georgia have been fortunate in having probably the best Regional Medical Program in cancer in the nation. The cancer program of the Georgia Regional Medical Program has consisted basically of four segments: (1) the area cancer facility program, (2) a tumor registry program, (3) a visiting consultant and workshop program, and (4) public education. The fundamental objective of the GRMP area cancer facility program has been to help develop "centers of excellence" in cancer prevention, diagnosis and treatment at the local level so that optimum patient care would be available within a reasonable distance of the patient's home. The principal objectives of the GRMP tumor registry program have been to assist in the follow-up of cancer patients and to provide a means for studying cancer and the results of treatment. The principal goals of the other programs are self-apparent.

As a result of the GRMP's efforts we now have around the state a number of well staffed and equipped area cancer facilities. In nearly every instance the cancer programs of these facilities have been approved by the American College of Surgeons. Several other hospitals in the state have been striving to meet the requirements which will enable them to be designated area cancer facilities.

In the past few years we have had an especially good series of cancer workshops due primarily to the joint efforts of the Georgia Division of the American

Cancer Society, the Committee on Cancer of the MAG, and the GRMP.

Goals of the Network

The proponents of a Statewide Cancer Management Network feel that we must strive to preserve and strengthen the system of Area Cancer Facilities already built by GRMP. But we must also go further. We know each physician wants to do a better job in cancer. We must push ahead and set up a network whose goals will be:

(1) To make available to every person in the state the fruits of modern knowledge in the prevention, early detection, diagnosis, treatment and rehabilitation of cancer.

(2) To provide ready access to the system for any patient *through his physician*.

(3) To provide high quality care for most cancer problems close at hand so that there will be a minimal disruption in the life of the patient and of his family.

To accomplish these goals there must be:

(1) A central administration with a broad voluntary grass roots support and financial support from state, federal and voluntary sources.

(2) Sound planning *involving the physicians who will be delivering the care*.

(3) A number of well equipped facilities scattered throughout the state manned by well trained physicians dedicated to cancer (the area cancer facilities).

(4) A system providing ready access to the latest information.

(5) A systematic plan for continuing education of physicians already skilled in the care of cancer.

The specific functions of the network will be:

(1) To establish an organization in which par-

ticipating members will meet together to plan several times a year.

(2) To establish criteria for the referral or interchange of patients to or from participating members.

(3) To develop, in cooperation, written standardized procedures for the detection, diagnosis and treatment of specific cancers. These statements will be reviewed and updated at appropriate intervals to make them reflect advances in the art.

(4) To provide a data retrieval system incorporating the current tumor registry system.

(5) To make a periodic inventory of our resources so as to identify gaps and to stimulate the filling of such gaps.

(6) To develop a system of mutual continuing education.

Possible Future Functions

Later some of the following functions might be added:

(1) To draft recommendations regarding standards of care.

(2) To make plans to avoid harmful competition and duplication of programs, staff, equipment and facilities.

(3) To review and comment upon all plans on the part of any participant to embark on new or expanded cancer-related programs or to make any substantial or significant change in service programs in clinical oncology which would affect any of the other participants.

(4) To develop and implement mutually acceptable specific and formal "ground rules" to facilitate all interinstitutional relationships which relate directly to the care of the patient with cancer such as:

(a) Developing and implementing appropriate agreements for the sharing of facilities, equipment and staff whenever and wherever feasible.

(b) When possible, agreeing upon fiscal mat-

ters which may affect third party reimbursement involving two or more participating institutions.

(c) Coordinating activities, including social service and home nursing, as the patient moves between participating institutions.

The general concept sketched above has been approved by the MAG Committee on Cancer. Assurances of support of the concept have been received from representatives of the Division of Physical Health in the Georgia Department of Human Resources, the Georgia Regional Medical Program, the Georgia Division of the American Cancer Society, the Medical College of Georgia and Emory University School of Medicine. The next step is to set up an Advisory Council to draw up the charter establishing the Network, its formal goals, policies and by-laws. It goes without saying, the Network Advisory Council must have broad, statewide representation from the medical profession as well as from lay groups. An *ad hoc* committee has been established to begin planning the establishment of the Network Advisory Council. Members of this planning Committee are:

Hoke Wammock, M.D., representing MAG

J. Gordon Barrow, M.D., GRMP

Elton S. Osborne, M.D., Department of Human Resources

John P. Wilson, M.D., American Cancer Society

Herbert E. Brizel, M.D., Medical College of Georgia

Charles M. Huguley, Jr., M.D., Emory University School of Medicine

A member of the Planning Committee recently stated, "I think this is a tremendously worthwhile idea and enterprise, but it needs grass roots support of all physicians in all parts of the state. We on the Committee want to know what our colleagues think about it. We welcome their comments."

You are urged to let members of this Committee know your views, pro or con, at an early date.

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The Impact of Changing Pesticide Usage on the Medical Community

ANNE R. YOBS, M.D., *Chamblee**

THE USE OF CHEMICAL SUBSTANCES has been increasing steadily in the modern world, filling man's physical environment with a myriad of substances which are potentially toxic to man himself or to parts of his environment. In trace amounts in the human body, some substances have no demonstrable effects, and others are essential to life; in larger amounts, these same substances may be toxic.

Similarly, the number and usage of pesticide products has increased significantly during the last 30 years with the availability of organic chemicals for convenient, effective, and economical pest control in a wide variety of situations. Benefits have included increased food production and control of disease vectors and nuisance pests. At first, relatively little effort was directed to safe application and controlled use of these chemicals, and knowledge of possible harmful side effects did not keep pace with the development of chemical pesticides. Beginning in the late 1940's, evidence developed that certain chlorinated hydrocarbon compounds, such as DDT, accumulate in fatty tissues of fish, birds, other wildlife, and man. Later studies showed that excessive concentrations of these pesticide residues have adverse effects on reproduction, physiology, and behavior in some birds and represent a threat to wildlife. The hazard to future generations of man is not known, but results of controlled experiments in laboratory animals indicate a need for further investigation.

The general use of DDT in this country was cancelled by the U.S. Environmental Protection Agency effective December 31, 1972, following several years of intensive review and inquiry into the environmental and human health hazards related to the use of this chemical. This administrative action will necessitate a change to other available chemicals, such as organophosphates and carbamates, which have been marketed for a number of years. They are more easily broken down in the environment and in biologic systems and therefore pose less risk of long-

range contamination and buildup in the environment. However, many of the chemicals which will be substituted for DDT are highly toxic and present greater short-range acute hazard to the user and to others coming into direct contact with them. Since these replacement chemicals are less stable, more frequent application will be required to maintain the same level of pest control, thereby further increasing the hazard—particularly to untrained users.

Project Safeguard

Project Safeguard, an intensive educational program directed to farmers at risk in 14 states, is a joint effort of the U.S. Environmental Protection Agency, U.S. Department of Agriculture, and the State Cooperative Extension Services. The target states include those southern and southeastern states where the greatest use of DDT has occurred in recent years in the treatment of their major crops, cotton, peanuts and soybeans. A special effort is also being made to alert physicians and emergency health personnel in these states to the potential problem and to review diagnostic and treatment measures with them.

Everyone engaged in health delivery should become familiar with all aspects of pesticide poisoning including prevention, populations at risk, signs and symptoms, diagnostic confirmation, and treatment. Review of all pertinent details is not possible within the space allotted, but a few salient points should be emphasized.

Pesticide poisoning is preventable if the user reads and observes all label instructions regarding usage, storage, and disposal. At risk are not only the farmers or applicators, but also their helpers and families.

Pesticides may be absorbed by ingestion, by inhalation or through the intact skin as a result of negligence, accident or deliberate action. Absorption of certain organophosphates is at least as effective following dermal exposure as after ingestion. Dermal exposure is of major importance in occupational poisonings, accounting for 77.5 per cent of the cases of occupational poisonings by industrial and agricul-

* Chief, Training and Education Branch, Operations Division, Office of Pesticide Programs, U.S. Environmental Protection Agency, Chamblee, Georgia.

tural chemicals in California in one year (Kay, 1964). There is wide variation in the toxicity of individual compounds within a given group of pesticide chemicals such as the organophosphates. Malathion has a low toxicity, while Temik, TEPP and ethyl parathion have considerably higher toxicity. Both the organophosphates and the carbamates inhibit acetylcholinesterase; organophosphates are permanent inhibitors, carbamates reversible inhibitors.

Illness results from accumulation of excess acetylcholine and, while similar, may vary in intensity from compound to compound and group to group. Signs and symptoms include sweating, headache, giddiness, miosis, tearing, increased salivation, excessive respiratory tract secretions, nervousness, blurred vision, weakness, nausea, vomiting, abdominal cramps, diarrhea; subsequent symptoms include chest discomfort, cyanosis, papilledema, muscle twitches, and in most severe cases, convulsions, coma and loss of reflexes and sphincter control. Miosis is commonly present, but mydriasis may occur; in either, pupils are nonreactive (Hayes, 1963). If symptoms begin more than six hours after the last known exposure, the illness is probably due to some cause other than pesticides. The end of exposure may be difficult to determine, especially if the patient does not practice good personal hygiene or continues to wear contaminated clothing or protective equipment.

Rapid delivery of correct treatment in suspected cases of pesticide poisoning is of primary importance. Treatment consists of **support, decontamination, and specific antidotes** where available. Support therapy includes, most importantly, administering artificial respiration when indicated, while maintaining a free airway. Mechanical means may be used if available; if not, mouth-to-mouth resuscitation should be followed. Oxygen should be administered when cyanosis or severe respiratory difficulty is present. Sedatives may be used with caution to combat hyperexcitability or convulsions; sodium phenobarbital is the drug of choice because of its rapidity of action but should be used with care when there is respiratory impairment. After continuation of respiration has been assured, decontamination of the patient should follow promptly to end exposure to the toxic chemical. Depending on the circumstances of exposure, decontamination may include one or more of the following: removal of contaminated clothing, washing of skin and hair, rinsing of eyes, gastric lavage or induction of vomiting and eventually evacuation of the intestinal tract.

Specific antidotes are not known for all pesticides, but antidotes of considerable value are available for use in organophosphate poisoning. They are safe enough to administer cautiously on the basis of symptoms before the diagnosis is firmly established. Favorable response to the antidote helps confirm the diagnosis. (Absolute confirmation requires laboratory analysis of proper samples to prove that a sufficient amount of the chemical was in the body at the time of onset of illness.)

Atropine sulfate is a physiological antidote which does not affect the inhibited cholinesterase but blocks the action of acetylcholine on parasympathetic receptors. Atropine sulfate should be administered to adults in doses of 2-4 mg intravenously as soon as cyanosis is overcome and should be repeated every 5-10 minutes until signs of atropinization appear. In all cases where atropine treatment is indicated, a mild degree of atropinization should be maintained for 24 hours and for 48 hours or more in severe cases. Doses for children should be proportional to weight, about 0.05 mg/kg body weight. Patients poisoned by organophosphates show an unusual tolerance to atropine because of the accumulation of excess acetylcholine.

Pralidoxime chloride (2-PAM chloride) (Protopam® Chloride, Ayerst Laboratories) is a specific antidote for poisoning by organophosphates, acting to break the bond between the enzyme and the pesticide metabolite. Treatment is more effective if started early and should always be given in conjunction with atropinization. The dose is 1 g for an adult and 0.25 g for infants, given slowly and preferably by infusion for 15-30 minutes. If infusion is not practical, the dose may be given slowly by I.V. injection as a 5 per cent solution in water over *not less than 2 minutes*. If the first dose produces improvement, it may be repeated after an hour. *2-PAM is contraindicated in suspected carbamate poisoning.*

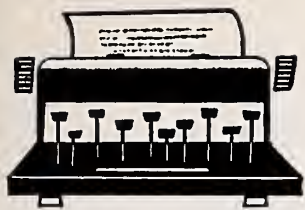
Patients who require treatment with antidotes should be watched continuously for not less than 24 hours, because serious and sometimes fatal relapse can occur due to continuing absorption or dissipation of the effects of antidotes.

A pamphlet entitled "Diagnosis and Treatment of Poisoning by Pesticides" developed by Project Safeguard discusses pesticide poisoning in more detail and is available in single copies on request to the author.

4770 Buford Highway 30341

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Highlights of AMA House of Delegates Actions

THE AMA HOUSE OF DELEGATES—confronted with the largest business agenda in the Association's history—acted on a wide range of issues during the 122nd Annual Convention, June 24-28, 1973 in New York, which affect physicians in their relationships with government, medical schools and hospitals, and with the public. The issues ranged from PSRO's and wage-price controls to institutional licensure and the need for more primary care physicians.

Elections

Delegates selected Malcom C. Todd of Long Beach, California as president-elect. In addition to Dr. Todd, others elected or re-elected to positions in the Association were:

Vice President: E. Bryce Robinson, Jr., Alabama

Speaker of the House: Tom E. Nesbitt, Tennessee

Vice Speaker of the House: William Y. Rial, Pennsylvania

Trustees: John H. Budd, Ohio (re-elected); Richard E. Palmer, Virginia (re-elected); James H. Sammons, Texas (re-elected); and Kenneth C. Sawyer, Colorado (re-elected).

The delegates, saddened to learn that J. Frank Walker, of Atlanta, Georgia, the Speaker of the House, would be unable to attend the convention because of a recent illness, approved a special resolution appointing Dr. Walker Speaker Emeritus, and commending him for his distinguished record of service to the Association.

PSRO

Two reports from the Board of Trustees outlining successful AMA efforts in providing physician input into the drawing up of PSRO regulations by the government, and in other areas, were filed by the House. In addition, two resolutions bearing on PSRO's were adopted. One resolution, initiated by California and amended, reads as follows:

Resolved, That the Secretary of Health, Education and Welfare be informed that the only organization which can give qualified peer review for physicians services to the patient, physician, government and taxpayer are those composed of practicing physicians, whether these are state or local groups; and be it further

Resolved, That since many of these practicing physician groups are functioning successfully, with multiple approaches, as peer review organizations, the regulations be so written to authorize these existing peer groups to continue their review as PSRO's or as functioning units of PSRO's, thus partially alleviating the unnecessary and costly implementation of new agencies as PSRO's.

The second resolution adopted as a substitute in response to a number of resolutions introduced, ranging from those calling for the AMA to go on record in opposition to PSRO's, to one urging the Association to seek repeal of the law. The sub-

stitute resolution, which conforms to PSRO policy approved by the House at the 1972 Convention, reads:

Resolved, That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care.

Wage Price Controls

Six resolutions were introduced protesting discrimination against physicians under the government's Economic Stabilization Program. The Reference Committee F pointed out that, "Although Phase III has officially ended, discrimination . . . has not been corrected and there is no assurance that other discrimination will not arise in the future."

Accordingly, the following substitute resolution was adopted by the House:

Resolved, That the American Medical Association continue to work by all lawful and practicable means to assure non-discriminatory treatment for physicians under present and future Economic Stabilization Programs.

FDA Drug Regulations

Six resolutions were introduced pertaining to FDA policies and regulations affecting the practice of medicine. The House adopted a substitute resolution which directs the AMA to, (1) Continue to protest proposed and current regulatory activities of the FDA which have the effect of restricting use of prescription drug to "official labelling"; (2) Study the possibility of proposing modifications to the Food, Drug and Cosmetic Act to correct current problems; (3) Continue to work closely with the FDA in the development of effective methods for evaluating drugs used primarily to alleviate subjective symptoms, or drugs for which controlled clinical studies seem inappropriate; and, (4) In continuing to work closely with the FDA, make efforts to develop an effective system of communicating the views of practicing physicians and medical specialty societies when action is proposed that may result in removal of frequently prescribed drugs from the market.

Institutional Licensure

The House adopted Report H of the Board which calls for the AMA to oppose the extension of institutional licensure in lieu of individual professional licensure to physicians and nurses. Testimony before Reference Committee D, including representatives of the nursing profession, was unanimously in support of opposition to institutional licensure.

Quality Assurance Program

The Quality Assurance Program (peer review of hospital care and utilization) of the American Hospital Association engendered considerable discussion. Resolution 50 called for the AMA to express its reservations about the potential of QAP to bring lay control of peer review. The House adopted Report H of the Board of Trustees which discusses the reservations, recommends that AMA representatives meet with the AHA to offer its suggestions on the program, and recommends preliminary testing of QAP in a limited number of hospitals. It is emphasized that, "This report is informational and does not imply endorsement of the Quality Assurance Program by the AMA."

Support for Medical Staffs

Lengthy debate centered on Resolution 104 from Illinois which protests unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs. Similar situations were reported in Arizona and South Dakota. A motion from the floor to refer the resolution was defeated. After considerable discussion, delegates approved the following substitute resolution:

Resolved, That the American Medical Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper; and be it further

Resolved, That unilateral changes in medical staff bylaws by hospital boards of trustees is also improper; and be it further

Resolved, That the AMA suggest that the following preamble be included in all medical staff bylaws:

The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgement and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

Physicians on Hospital Boards

The House also approved a substitute resolution calling for (1) increased medical staff representation on hospital boards; (2) state and local medical society efforts to remove barriers to such representation; and (3) that the Joint Commission on Accreditation of Hospitals ascertain from its inspectors the effectiveness of communications between hospital governing boards and medical staffs.

Physician Distribution by Specialties

The House approved Report Z of the Board of Trustees which has important implications for the medical profession and for the public. The report outlines the increase in number of medical schools, the increase in approved residencies and internships, and the increased number of allied health and continuing medical education programs. The report, as amended by the House, also contains two important recommendations. They are:

AMA should adopt immediately, publicize widely and promote vigorously a goal to have at least 50 per cent of all medical graduates enter residency training in the primary care specialties in the coming years.

The need for numbers and type of physicians should be monitored continuously and reassessed periodically in regular reports to the House of Delegates.

Emergency Telephone Number

Resolution 145, introduced by the Texas Delegation, highlights the importance to the public of a universal emergency telephone number for obtaining emergency care and directs the AMA to support and collaborate in current efforts to set up #911 as the nationwide emergency telephone number. A motion from the floor to refer the resolution was defeated, and the House adopted the Texas resolution.

Temporary Licensure for Physicians in Medically-Deprived Areas

The House adopted Report I of the Board of Trustees which encourages state medical societies to support amendments to the medical licensure laws to permit

out-of-state physicians to practice temporarily in areas of medical need. The report also encourages state medical licensing authorities to take similar action to permit temporary licensure for physicians voluntarily serving in medical shortage areas under the National Health Service Corps or the AMA-sponsored Project USA.

Unions

The House adopted Resolution 86 (New York) which reaffirms the tradition of the medical profession of not withholding medical services (withholding services is a practice of most unions), or performing any act interfering with public welfare. The House also approved Report F of the Board of Trustees which opposes unionism among self-employed physicians. The report also recognizes that physicians in employment situations need assistance and support, and encourages the Board of Trustees to maintain its interest and concern for these physicians. The report also affirms the no-withholding of services principle.

Malpractice

The House took several actions in regard to medical malpractice, including approval of Report GG of the Board of Trustees which outlines the proposed formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. The proposed commission was outlined by a planning committee consisting of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians and four specialty societies. An organizing meeting for the proposed commission will be held in Chicago in September.

Intern-Resident Membership on Councils

After considerable discussion, delegates adopted Report A of the Council on Constitution and By-Laws which will change the by-laws to provide a seat on the Council on Medical Service and the Council on Medical Education for a representative for resident-intern members of the AMA. Debate centered not on the desirability of adding intern-resident representatives, but on the wisdom of mandating a seat for any particular medical group. The House acted favorably after a plea from Dr. Eugene S. Ograd, resident-intern delegate, that adoption was needed to further promote resident-intern membership in the AMA. In a related development, the House also approved Report BB of the Board of Trustees for the establishment of a Committee on House Staff Affairs. The committee is intended to strengthen intern and resident participation in organized medicine, and advise the Board of matters of special concern to house officers.

Separation of Business, Scientific Meetings

The House took a compromise position on Report E of the Council on Long-Range Planning and Development which called for, among other things, separation of House of Delegates' meetings and Scientific meetings; holding all meetings of the House in Chicago; and the selection of widely separated locations for scientific meetings. The House adopted Reference Committee F recommendations that a meeting of the Scientific Assembly be held each year in conjunction with the Annual Convention, but that one or more additional meetings of the Scientific Assembly be held each year at times and places selected by the Board of Trustees on recommendations from the Council on Scientific Assembly. Such meetings might . . . or might not . . . conjoin with the Clinical Meeting of the House. The proposal that all House sessions be held in Chicago was rejected, and existing meetings of the House and Scientific Assembly scheduled through 1976 will not be changed.

Formal Planning System for the AMA

Delegates approved Report D of the Board of Trustees which details a comprehensive, formal, long-range planning system for the AMA designed by Batelle Laboratories, Columbus, Ohio. The plan will improve the AMA's ability to sense change, sharpen objectives, allocate resources, measure progress and improve communications between the AMA and constituent societies and membership.

Abortion

Reaffirmed the AMA abortion policy which states, "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice and the Medical Practice Act of his state. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment or personally held moral principles."

The Current Status of RMP

THE PRESIDENT'S ORIGINAL budget proposal for FY 1973 called for \$130 million for RMP—the largest amount ever proposed. However after the successful veto of the HEW Appropriation Bill, re-apportionment of the budget by the administration markedly reduced the sum to less than \$60 million. In January of 1973, it was announced that the President's 1974 budget proposal to Congress would not contain any request for RMP. This decision was apparently made at the highest levels of the Administration, since every level of HEW up to and including Dr. Duval, the Assistant Secretary for Health, had recommended continued funding for RMP in 1974.

In February of this year a phase-out order was received by each RMP in spite of the fact that Congress had not yet made any decisions regarding extension legislation for RMP and a number of other health programs. Opposition to the dissolution of RMP became widespread among most of the major national health organizations, and in Congress. Eventually, in spite of tremendous pressure by the Administration, Congress overwhelmingly voted to continue RMP as well as 12 other health programs scheduled for phase-out or major reduction.

The President has now signed the bill for a one year extension of RMP with the understanding that a major revision of the entire Public Health Service Law will be made during the year. There is currently every reason to believe that RMP will be continued and strengthened in this revision.

Since a 1974 HEW Appropriation Bill has not yet been passed by Congress, money is being released on a continuing resolution which holds the level of expenditures to that of last year. Although this will mean a limited program in Georgia, at least for the first quarter of FY 1974, it is expected that the Appropriation Bill will be passed soon and a level of funding released which will allow a revitalization of the Georgia RMP program. As soon as details of the program for the year are known, you will be informed.

Your interest in and support of RMP is greatly appreciated and we will continue to make every effort to justify this support.

*J. Gordon Barrow, M.D.
Director*



Convention in a Nutshell

THE 122ND ANNUAL CONVENTION of the AMA is now history. Held in New York City at the Americana Hotel June 23-28, your MAG delegation was hard put in an attempt to cover nine reference committees with more than 160 resolutions and more than 50 reports on topics ranging from abortion to physicians unions and Professional Standards Review Organizations. Because of illnesses and other emergencies, your delegation to the AMA was hampered by a serious shortage of personnel.

Each of us should be grateful to our hardworking AMA delegates and alternates for the many long hours spent on our behalf before and during the AMA convention. Each resolution and report had to be read and discussed before and after reference committee meetings in order for our delegation to vote or debate wisely the issues that came to the floor of the House of Delegates.

The Georgia delegation and indeed all MAG is saddened by the resignation of J. Frank Walker, M.D. as Speaker of the House of Delegates of the AMA on the advice of his personal physician. The House of Delegates in New York unanimously elected Frank permanent Speaker Emeritus of the AMA House of Delegates.

The convention was picketed on Sunday by three groups: the pro-abortionists on the opposite sidewalk; the anti-abortionists on the near sidewalk; and the gays in the street!

It is evident that the MAG Council and Budget Committee must consider increasing the allowable daily per diem expenses of our AMA delegation. Hotel and food costs in the larger cities are far in excess of the current daily allowance.

The complete convention report is printed in the July 5 edition of *American Medical News*.

A handwritten signature in cursive script, reading "Charles E. Bohler, M.D.".

Charles Emory Bohler, M.D.
President, Medical Association of Georgia



RUPTURE OF THE VENTRICULAR SEPTUM COMPLICATING ACUTE MYOCARDIAL INFARCTION

ALAN E. KRAVITZ, M.D., *Atlanta**

NECROSIS OF THE INTERVENTRICULAR septum with subsequent perforation (VSD) is a rare but dramatic and life threatening complication of atherosclerotic heart disease and acute myocardial infarction. Its frequency is estimated at 1.2 per cent of all myocardial infarctions, occurring almost exclusively at the time of first infarction. Of all patients with acute infarction coming to post-mortem examination, 2 per cent were found to have septal rupture, usually associated with massive transmural necrosis and free wall aneurysm formation. These statistics suggest that this complication will occur 10,000 times to the one million Americans anticipated to have myocardial infarction in 1973.

Prognosis for the untreated patient is grave. In a series prior to the advent of surgical therapy, 24 per cent of patients having acute septal rupture were dead within the first day, 87 per cent within two months and only 7 per cent were alive at one year.

Development of Technique

Latham first recognized acquired ventricular septal defect as a complication of myocardial infarction in 1845. Nearly 100 years later Beck treated a patient with a postinfarction ventricular aneurysm, but no VSD, with a fascia lata patch graft. Denton Cooley reported the first open repair in 1957. The patient was a 49 year old male who sustained a VSD five days following clinical infarction. He was treated medically for 10 weeks, then taken to surgery. He apparently did well initially, but died suddenly six weeks later of a second infarction. In 1962 the surgical technique for combined aneurysmectomy and VSD repair was reported. A large number of such patients has been reported, more frequently by surgical than medical cardiologists. Diagnosis is easily made if complications of infarction are thought of and careful examination is done. The typical patient presents four to 10 days following the "clinical" infarction with sudden and unexpected recurrence of severe precordial pain, nausea and profound diaphoresis. Physical examination reveals a new harsh holosystolic crescendo-decrescendo murmur associated with a thrill, usually at the left lower parasternal border, but occasionally at the apex. The murmur radiates widely throughout the precordium. Suddenly increasing congestive heart failure and frequent shock complete the bedside picture. Diagnosis can be made in the Coronary Care Unit with benefit of Swan-Ganz flow-directed catheter. An increase in blood oxygen content from the right atrium to the right ventricle is demonstrated. If the peripheral arterial blood oxygen content is measured simultaneously, the magnitude of left to right shunt is easily calculated. Usually pulmonary

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

blood flow is four times systemic and pulmonary vascular resistance is decreased. Angiography is not required to confirm the diagnosis.

Review of the recent literature reveals nearly 200 surgically treated cases. Only 45 have been completely reported and are included in this analysis. While the youngest reported surgically treated patient was 45 and the oldest 76, the patients appear to be evenly distributed in the fifth, sixth and seventh decades. In all, infarction was extensive and transmural, but the anatomic locations appear nearly evenly distributed among inferior, anterior and apical surfaces of the left ventricle. The mean interval from clinical infarction, by symptoms, to rupture was eight days but the earliest occurred within hours and the latest at 23 days. Mean delay from recognition of rupture to surgical correction was eight weeks in this series with the earliest attempt within hours (unsuccessful) and the latest eight years following infarction in an asymptomatic female whose pulmonary flow was 1.5 times systemic.

Assessment of functional presence of an aneurysm is made directly by the surgeon, with the heart exposed, prior to cardiopulmonary by-pass. Most surgeons agree that an aneurysm, if present, should be excised and the ventriculotomy done through the aneurysmal wall. VSD is visually identified and a teflon patch is placed on the left ventricular surface of the septum, buttressed by teflon pledgets in non-infarcted myocardium. The free wall of the left ventricle is then approximated. The smallest reported VSD repaired was 1 cm.² and the largest attempted 12 cm.² The latter patient had such extensive left ventricular necrosis that following surgical tailoring an ample left ventricular chamber could not be restored. The mean anatomical size was 3 cm.² Several patients have been maintained on an intra-aortic counterpulsating balloon pump while awaiting surgical repair. This new treatment modality "buys time" by increasing peripheral flow, increasing coronary arterial flow (thus tending to decrease infarct size) and decreasing the magnitude of the left to right intracardiac shunt.

Important Correlations

The reported cases are perhaps biased favoring the more salutary results. Nevertheless important correlations may be made comparing the interval from clinical rupture to surgical repair with survival (one month or left hospital). Only 33 per cent of patients operated in the first week survived, 71 per cent of those operated between first and third weeks survived and 95 per cent of patients operated after four weeks survived. These data suggest that allowing the acute infarction to complete itself both electrically and morphologically yields surgical candidates with better prognosis. It is a clinical fact, however, that patients with larger and more serious infarctions are selected from the surgical candidates by death prior to anticipated surgery.

Results in these 45 patients indicate better prognosis if aneurysmectomy or infarctectomy is done at the time of VSD repair and if the VSD is patched rather than the free edges approximated. A recent review of long term survival of all patients undergoing surgical repair suggests only 25 per cent survive one year. This serious attrition rate, in addition to surgical deaths, is related to the underlying severity of coronary artery disease, with death usually following a subsequent infarction.

Current concepts in surgical care for the acute VSD, following definitive diagnosis, have been summarized by Shumway: "As soon as the patient develops unremitting, medically refractory heart failure, surgery is indicated, regardless of the time relationship to infarction or perforation."

1938 Peachtree Road, N.W. 30309



REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE: A SUMMARY

RICHARD METZGER, *Atlanta**

“**A**S A PHYSICIAN, I live in an aura of fear—fear of suit. Fear contributes to hostility and rarely contributes to constructive action. . . . The house of medicine feels belabored. Medical organizations are trying their best to overcome their deficiencies, but in my opinion, malpractice litigation is not the best incentive to improvement.” (Secretary's Commission Report, Statement of Dr. George Northrup, pp. 105, 106)

This statement might be regarded as the keynote to the work of the Secretary's Commission on Medical Malpractice (Dept. of Health, Education, and Welfare), the report of which was recently published. The Commission's study is of obvious importance to physicians, lawyers and all members of the public; while it is not the first effort in high levels of government to approach the problem of increasing malpractice claims and attendant social and economic costs,¹ it is the first real attempt to offer solutions to the problem. The Commission's study may be a start in that direction. This article is an attempt to review some of the Commission's findings and recommendations.

Defensive Medicine

Testimony and data presented to the 21-member Commission indicated that the rising number of medical malpractice suits is leading some physicians to practice “defensive medicine.” The term is defined as “the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted.”

The Commission concluded that “defensive medicine is a by-product of medical-legal liability problems and not a causative factor in itself.” While causes lie elsewhere, and permanent solutions will be explored in due course, the Commission's official recommendations on the subject of defensive medicine clearly place the burden of temporary correction upon the medical sector. The Commission recommends that physicians themselves should lead an “aggressive attack” against overutilization of health care resources. The Commission urges medical and osteopathic organizations to “exert maximum moral suasion over physicians who avoid professional responsibilities on the basis of fear of liability.”

Medical-Legal Problems: Litigation

Several specific medical-legal issues were considered by the Commission; also considered was the general strain which, instead of the necessary co-operation, seems to mark relations between the medical and legal professions. The Commission finds physicians' fears in some areas of malpractice law unjustified. After re-

* Prepared at the request of The Medical Association of Georgia, Mr. Metzger is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

viewing numerous documented instances of physicians acting in what is commonly referred to as the "Good Samaritan" role,² it was found that "there is no factual basis for the commonly-asserted belief that malpractice suits are likely to stem from rendering emergency care at the scene of accidents," and the Commission recommends that "widespread publicity be given to this fact in order to allay the fears" of health care providers.

With respect to those emergency situations not covered by most "Good Samaritan" statutes and which often result in malpractice actions—the example is given of a "dead" woman, in a hospital, who was restored to life by closed-heart massage but whose ribs were broken in the process—the Commission urges all states to enact legislation providing qualified immunity to physicians and other health-care personnel acting in such situations.

The Commission cites a lack of uniformity in the application of certain other legal doctrines affecting medical practice, and the Commission corroborated fears voiced by the medical profession that the doctrines were being judicially expanded in a series of unjustified, plaintiff-oriented trends. For instance the doctrine of *res ipsa loquitur*³ has been extended beyond its classic framework to cases of rare medical accident.⁴ If the courts use the doctrine to allow circumstantial evidence to replace expert testimony as the sufficient factor in a plaintiff's *prima facie* case, physicians are in effect put in the position of having to prove freedom from negligence without the plaintiff having to prove—other than inferentially—that any negligence occurred.

The Commission felt that judicial expansion of *res ipsa* and other cited legal rules is partially a reaction to the inability of plaintiffs to obtain the necessary expert medical witnesses to testify in their behalf against defendant physicians. But the Commission noted that the alleged "conspiracy of silence" among physicians is on the decline. To insure the continued trend toward ready availability of expert witnesses, the Commission encourages organized medicine to cooperate fully in medical malpractice actions, and specifically encourages "the establishment of pools from which expert witnesses can be drawn."

Other medical-legal issues—informed consent to medical treatment, the "discovery" rule under the statute of limitations, the expansion of strict liability theory of tort law—are all given considerable discussion in the course of the Commission's study. The Commission stated that its goals with respect to most medical-legal issues are logic, consistency, uniformity, and comprehensibility by members of both medical and legal professions. To these ends, the Commission recommends the drafting of a "Restatement of Medical-Legal Principles"⁵ by "a broad-based group, representing all segments of the health-care system, the legal profession, and the general public."

Alternatives to Litigation

Among the preventive measures discussed are improvements in licensure and discipline among physicians and other health-care providers. Finding that "most state medical practice acts do not have adequate provisions for disciplining practitioners who have been found incompetent," the Commission urges all states to, among other things, to revise licensure laws to require periodic re-registration of health care personnel based on proof of participation in continuing medical education programs.

While the proposals on medical-legal principles discussed earlier cited fairness and uniformity as ideals, in several recommendations aimed at prevention of full-blown litigation and of patient injury in the first place, special treatment is called for.

The Commission recommends, for instance, that state laws should require pa-

tients to give written notice to potential defendants of their intent to file a malpractice suit. Upon the filing of such notice, the statute of limitations would be automatically extended for a specified period to enable the parties to negotiate an amicable settlement.

In another section, the Commission notes that plaintiffs are expected in almost all states to claim specific dollar amounts in the "ad damnum" clauses of their pleadings, and too often they are induced to plead ridiculous amounts, out-of-proportion to the suit's real worth, thus causing sensational coverage in the media and unnecessary friction between the medical and legal professions. The Commission recommends "that the states enact laws eliminating inclusion of dollar amounts in *ad damnum* clauses in medical malpractice suits."

The Commission sees extreme danger in delays pending the duration of judicial *ex parte*⁶ "stay-of-revocation" orders. Under current practice, a Board may revoke the license of a doctor who may then, perhaps on that same day, appear in Court to obtain an order staying the revocation and allowing him to temporarily continue his practice. The Commission fears that State Boards' efforts to enforce toughened licensing and disciplinary regulations can be thwarted for months and years by dilatory *ex parte* practice. Seeking "special treatment" once again, the Commission recommends that states enact legislation limiting the duration of such "stay orders" to the minimum period necessary to hold an adversary hearing on the issue of suspension or revocation. The Commission asks that the adversary hearing "be given priority on any Court docket."

Of all the alternatives and adjuncts to current modes of malpractice litigation which are discussed in the Commission's Report, local screening panels and arbitration are given the most serious consideration.

The object of the local screening panel, customarily established by medical societies, either alone or in cooperation with bar associations, is to provide a quick and inexpensive determination of whether or not a malpractice claim has merit. Finding that the procedure has limited usefulness in many situations, particularly in those cases involving more than one defendant, the Commission nevertheless "recognizes the value of local efforts to mediate medical malpractice disputes, and therefore recommends continuous experimentation with voluntary mediation devices."

The Commission examined various types of arbitration schemes currently in practice, both "imposed arbitration" and arbitration "by agreement of the parties," in an attempt to outline features of such plans that would best be adaptable to widespread handling of malpractice disputes. Speed, inexpensiveness, and protection of individuals' right of privacy and their freedom to contract were attributes most frequently cited. Some of the specific recommendations concerning arbitration are:

1. State arbitration laws should set a maximum monetary limit for invoking the jurisdiction of the arbitration board, with cases demanding higher amounts being handled through the present jury system.
2. Arbitration panels should include some persons who are neither attorneys nor persons involved in the delivery of health care services.
3. There should be a right to trial *de novo* subsequent to arbitration in the highest level jury court in the State.
4. No patient should be required, as a condition for receiving service, to sign an agreement requiring him to agree to arbitrate any future dispute arising out of the service.

The Commission found Georgia's arbitration statutes⁷ to be particularly appropriate for medical malpractice arbitration in terms of procedural safeguards afforded and other affinities with the ideals outlined by the Commission.

Summary

This has been an attempt to provide only a brief sketch of what the Commission

accomplished in its report, a document which, with appendix, runs more than a thousand pages in length and which is in itself a summary of voluminous testimony and other source materials. The Commission dealt with other pieces to the malpractice puzzle in great detail—insurance availability and costs, alternative insurance plans, rating systems, effect of Medicare, educational needs and programs, access to medical records, human experimentation and protection of research subjects, the role of the Federal Government, and the evils of the contingent legal fee, to name some of the topics discussed—and all of the Commission's findings and recommendations deserve close scrutiny and analysis. It is hoped that, in coming months, the pages of this *Journal* will afford the opportunity for a closer look at some of these problems.

It is important to note that the "majority report" summarized here was by no means a unanimous set of conclusions. Many of the physician members of the Commission dissented from one or more of the majority's findings and recommendations, and several members shared the frustration of a sudden halt to the Commission's deliberations and the imposition of what was felt to be a premature filing deadline. It appears from the Final Report that Commission members had less than a week to study and react to a Draft Report before the unexplained, hurried deadline. And it appears that members had no time at all to study many of the major research materials that make up the bulk of the Appendix to the Report.

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REFERENCES AND NOTES

1. The first Congressional study of the burgeoning malpractice problem appeared in *The Patient Versus the Physician, A Study Submitted by the Subcommittee on Executive Reorganizations, Committee on Governmental Operations, U.S. Senate, 91st Congress, 1st Sess. (1969)*.
2. See Ga. Code Ann. sec. 84-930; J.M.A.G. Jan. 1973.
3. Translated roughly "the thing speaks for itself," the phrase denotes an evidentiary rule that is permitted to be invoked when (a) the claimed injury is of a type that ordinarily does not occur except for someone's negligence, (b) the conduct or mechanism which caused the injury was in the exclusive control of the defendant, and (c) the plaintiff was free of contributory negligence. The plaintiff is afforded an inference of negligence on the defendant's part sufficient to allow his case to go to the jury; the burden of producing exculpatory proof is shifted to the defendant.
4. *Seneris v. Haas*, 45 Cal 2d 811, 291 P. 2d 915 (1955); *Clark v. Gibbons*, 77 Cal 2d 399, 426 P. 2d 525 (1967); Prosser, *Law of Torts*, 3d Ed, 1962, p. 231.
5. "Restatements" are now in existence in many areas of the law, and are often influential as guides to judges and as models for legislators.
6. In an *ex parte* hearing only one side ordinarily appears.
7. Ga. Code Ann Secs. 7-201 through 7-224.

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THE ASSOCIATION

PERSONALS

First District

John Vaughn and **Herman Delancey** of Savannah co-authored an article, "Multiple Carcinoid Tumors of Stomach," which appeared in the June issue of the *Southern Medical Journal*.

Peter L. Scardino, Savannah, has been appointed clinical professor of surgery in urology with the Medical College of Georgia. Dr. Scardino is program director of the Department of Urology, a teaching position in the Memorial Medical Center's Graduate Medical Education Program.

Second District

Jack Hudson, graduate of the Medical College of Georgia, has opened an office for the general practice of medicine in Camilla bringing the full time staff of doctors at Mitchell County Hospital to five.

Fourth District

Harry R. Foster, Jr. has been joined in the practice of pediatrics and neonatal medicine at Four Oaks Medical Center in Lithonia by **Jordan A. Dean, Jr.**, who has just completed his pediatric residency at Grady Memorial Hospital. Dr. Dean is a graduate of Emory University School of Medicine.

Fifth District

Arnoldo Fiedotin and **Simon W. Rabkin** co-authored an article, "Chronic Postreumatic Arthropathy (Type Jaccoud): Report of Two Cases and a Review of the American Literature," which appeared in the June issue *Southern Medical Journal*.

Carter Smith, Sr. of Atlanta recently was honored by the American College of Physicians which designated him a Master of the College. The only other Georgians previously accorded this honor were Dr. Edgar Paullin and Dr. Thomas Findley.

Atlanta cardiologist **Nanette Kass Wenger** is the author of a major article in the July issue of *Geriatrics*. Dr. Wenger is a graduate of Harvard Medical School and is a professor of medicine at Emory University School of Medicine.

Tenth District

Zachariah W. Gramling, professor of anesthesiology at the Medical College of Georgia, has been appointed chairman of the Department of Anesthesiology effective July 1, 1973. Dr. Gramling received his M.D. degree from the Medical University of South Carolina and has been on the faculty of MCG since 1960.

Several Medical College of Georgia faculty members have recently received grants for their work. They include: **James B. Hudson**, a grant from the Department of Human Resources and Providence Life Insurance Co. for kidney patient care; **Marshall B. Allen**, for neurological surgery; and **Arthur L. Humphries**, a grant from the National Institute for General Medical Science for continuation of a program on "Storage of Kidney by Hypothermia and Profusion."

Armand B. Glassman of the Medical College of Georgia presented two papers at a recent meeting of the Association of Clinical Scientists in Tampa, Fla.

Mark Brown, Augusta, of the Medical College of Georgia, contributed a chapter to the newly published book, *The Biology of the Human Dental Pulp*.

DEATHS

William W. Meriwether

Macon physician William W. Meriwether, 83, died June 13 in a local hospital following a long illness.

The Alabama native had lived in Macon 60 years. Dr. Meriwether was graduated from the Atlanta School of Medicine (now Emory), then served over 50 years as a state public health physician. He also served as a city physician 25 years and was on the staff of the Medical Center of Central Georgia.

Dr. Meriwether was a member of Macon Lodge No. 5, F. and A.M., the Scottish Rite, the Shrine and First Methodist Church of Montgomery, Ala.

Survivors include one son, W. W. "Bill" Meriwether, Jr., of Macon; two sisters, Miss Julia Meriwether and Miss Mabel Meriwether of Montgomery, Ala.

Bithel Wall

An automobile accident July 7 claimed the life of 52-year-old Bithel Wall of Americus.

Dr. Wall was born in Sylvester and attended the University of Georgia and Medical College of Georgia. His internship was served at Grady Memorial Hospital and his residency at Barnes Hospital in St. Louis, Mo. He had been awarded a one-year scholarship to Sloane-Kettering Research Hospital in New York.

He came to Americus from Tampa, Fla. two years ago and was a member of the Americus Kiwanis Club and Country Club, the First Baptist Church of Sylvester, and the American Rose Society.

Survivors include his widow, Mrs. Anna LaRoache Wall; son, Bithel Wall, III, both of Americus; mother, Mrs. W. B. Wall, Sr., Sylvester; two brothers, John K. Wall of Atlanta and James Hilton Wall of Monticello, Miss.

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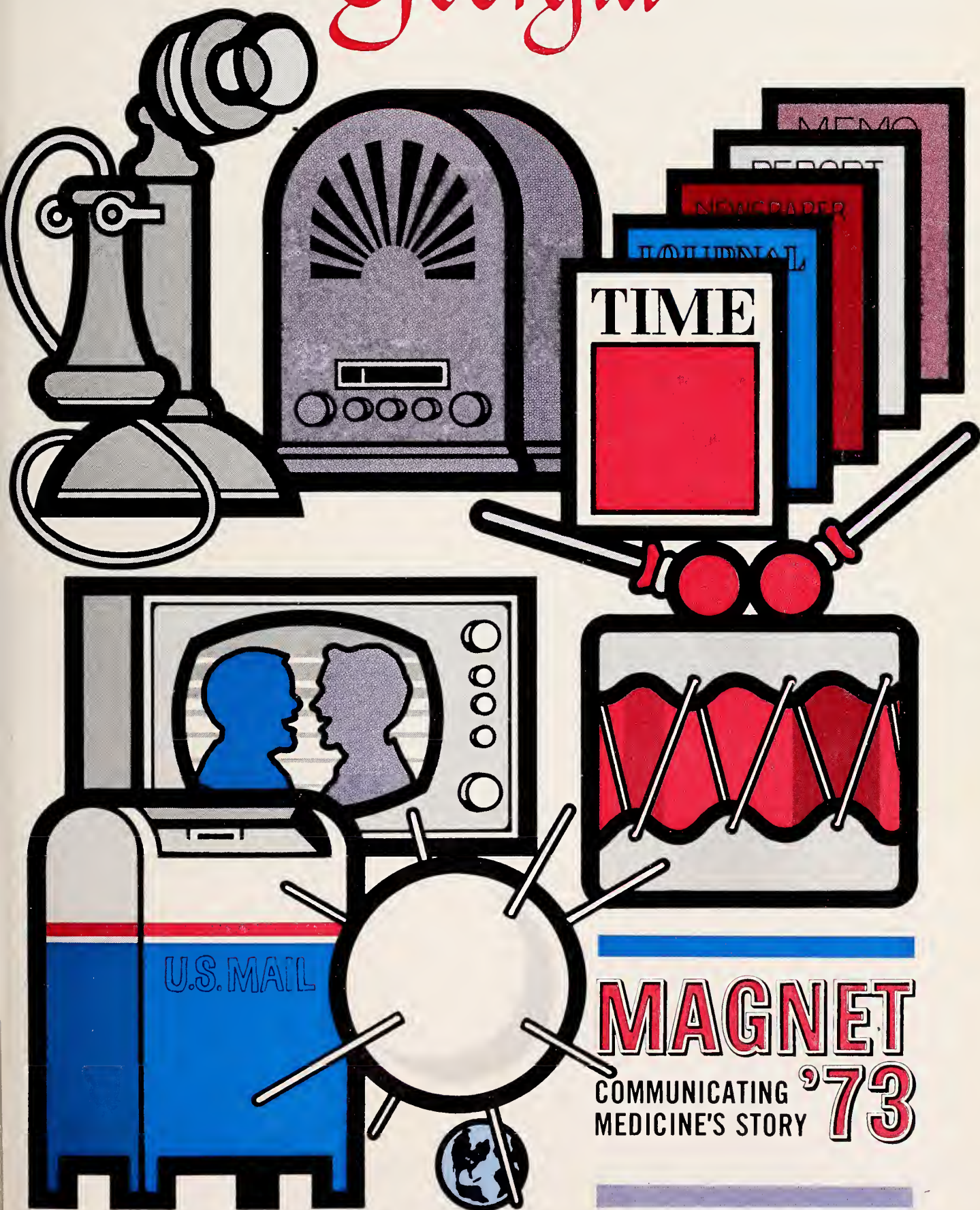
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Cover

Many forms of communication, from the primitive drum to today's electronic media call attention to the theme of the 1973 MAGNET Conference, November 3-4 in Atlanta. For details, see page 316. Cover by artist Bob Hamill of Atlanta.

The author calls for a unity of physicians to deal with government's power and society's needs.

The Need for Medical Leadership

JOHN R. KERNODLE, M.D., *Burlington, N.C.**

THE BASIC MESSAGE I BRING you today is the need for leadership. Among us physicians, that need is critical . . . and never more so than today.

By calling for more leadership, I do not mean that more men should be forming more committees or assuming more titles. My stress is not on *what* we lead but on *where* we lead . . . not on authority wielded but on directions taken.

Above all else, leadership today means the navigator's skills we bring to the health-care problems that are in a troubled sea around us all.

Old as the AMA and your society are, they necessarily become new each day. Every new issue or action in the field of health makes us new . . . in the way it changes our professional lives and compels us to adjust.

Stress Flexibility

Thus, the leaders of organized medicine must ever think anew. They cannot afford the comfort of fixed ideas or fixed ways. They must be flexible and resourceful.

Flexibility includes national and state medical leaders working together . . . and finding new ways of working together. There are no purely national or state problems. What Washington does affects you, and what your legislature does can influence Washington. Your actions and mine must be as coextensive as our problems.

Differences of view between the AMA and its state affiliates are healthful . . . and nourish us. But while *unison* cannot be expected, we must have *unity*. Either we shall be stronger than our common problems or they will be stronger than we are.

Having said this, I return to my original premise:

the directions which leadership should take.

I shall tell you what courses the AMA is pursuing on major issues . . . pursuing in your behalf. In so doing, I shall raise the question: What more can we strive for . . . together?

The AMA is staunchly resisting governmental encroachment on our freedom as doers and achievers. However, absolute freedom—amid the unfilled health-care needs of society—would be as Utopian as absolute governmental control of medicine.

In every legislative confrontation, we must seek the best possible options—in the light of governmental encroachment on our freedom. And we must exercise those options as promptly and capably as possible—before they become fewer and worse.

The AMA believes it has been doing so on the various issues . . . including peer review.

Peer Review Conflict

For some time—and ever since the passage of Medicare and Medicaid—many instrumental people have preached that a measure of governmental control over peer review was inevitable. It was dictated by the intervention of third parties in the practice of medicine . . . by their role in Medicare and Medicaid . . . by government's financial responsibility for these programs . . . and by the frequent conflict between compensation and services.

The basic question now is not the fact of control . . . but the method and degree of its application.

A bill introduced at the 92d Congress would have given the government a strong, chilling hand in peer review of Medicare and Medicaid. Bureaucrats unversed in medicine would have begun overseeing and evaluating our work.

Cherishing the conviction that only we physicians can evaluate the performance of our peers, the AMA

* Dr. Kernodle is chairman, American Medical Association Board of Trustees. This address was presented at the 119th Annual Session of the Medical Association of Georgia May 11-13, 1973 in Augusta, Georgia.

LEADERSHIP / Kernodle

was instrumental in getting a modified bill passed . . . in seeing that state and local medical societies are given the opportunity—if they so wish—to set up independent Professional Standards Review Organizations that comply with the law.

But the carrot is accompanied by a stick. We must see that our direction of this peer review is a strenuous, dedicated effort . . . not a cop-out. The trust that Congress has placed in us is conditional. Think what our forfeiture of that trust could mean—particularly if PSRO, at some time in the future, is extended from Medicare and Medicaid to health care generally.

All of us must work in coordination—at the local, state, and national levels—to make the most of our best option.

We must demonstrate our awareness of the need to conserve the patient's health-care dollar . . . educate and inform one another in the economics of care . . . ensure appropriate use of personnel and facilities . . . and maintain impeccable standards of medical practice.

It is auspicious that a great majority of the state medical societies have said they would apply for designation as PSROs.

The AMA, for its part, intends to monitor PSRO closely—not only to help ensure its effectiveness . . . but to help safeguard the interests of physicians.

We are well aware that the costs of care cannot be controlled solely by the providers of care.

For example, government must recognize the cost impact of our protection and defense against malpractice claims. It should realize how capricious and opportunistic many of these claims are . . . and how they are encouraged by increasingly permissive legal formulas.

Little such perception appears in the final report of the Commission on Medical Malpractice that was appointed by the Secretary of Health, Education and Welfare. The report places the onus on health providers and on the quality of care . . . and relegates the standardization of legal doctrines to another group.

The AMA staunchly opposes any move by HEW to adopt the report. Of course, regardless of what happens in Washington, much of the effort to achieve legal equity and balance must be waged in the states. Therefore, the AMA has been encouraging state medical societies to seek appropriate statutes.

AMA Services

Because so many issues are affected by legislative interplay between the nation and states and among

the states, the AMA headquarters is hiring an attorney who will analyze legislative trends . . . and alert state medical societies to them. His thoughtful coordination of data should prove a real service to your staff.

On legal problems, too, the AMA tries to be of service to its affiliates and members. In California, the AMA is supporting a physician's suit contesting the authority of the HEW Secretary to freeze reasonable charges under Medicare. In Philadelphia, we are backing a physician's denial of financial responsibility for a hospitalization that Blue Cross deemed needless.

What brings the big American Medical Association into an action involving one physician in a small claims court in Philadelphia?

First, a principle is involved . . . and the defeat of a principle in one corner of the land can become a pattern for the entire land.

Second, the AMA, as an aggregate of individuals, puts as much stress on the individual as it does on the aggregate.

The AMA wants to be of service to each of you . . . and in any arena, small or large. We are trying to do effective service for you in the greatest arena of all—the District of Columbia, where bills on national health insurance and Health Maintenance Organizations are honing their spurs.

Senator Ted Kennedy expects his own insurance bill to become the law of the land within two years . . . and its backers are assembling a huge “grass-roots” campaign to bring that prediction to pass.

I believe that their hopes will be in vain. I believe the American public will see their program for what it is—as another lavish float in the vainglorious parade that was given us the war on poverty . . . the welfare programs that have fared so ill . . . the vertical slums masquerading as housing projects.

Yes the public will see that—but the facts must be brought home to them. We must have our own grassroots campaign . . . with your cooperation.

Counter Plan: Medicredit

The campaign must not be negative . . . and need not be. We have our own bill for national health insurance—the Medicredit plan approved by delegates from yours and the other state bodies that compose the AMA.

The AMA is conducting an “Action '73” program that will inform our profession and the public about the merits and goals of Medicredit. Your field representative can give you the details.

We must make it known that Medicredit is not an empty gesture or a decoy or a blocking action. It is submitted to the American people with thoughtful solicitude . . . and with respect for their budgets.

their needs, their hopes. Already it has 163 Congressional sponsors . . . more than any rival proposal.

We must make it known that Medcredit would offer everyone substantially the same scale and range of benefits as the Kennedy plan . . . including coverage of outpatient care, dental care, psychiatric care, and catastrophic illness.

We must make it known that the \$81 billion annual cost of the Kennedy bill is not matched by any promise of success—even in the financing of care. Indeed, the most conspicuous aspects of its financing would be its underfunding. The special taxes and general revenues it calls for would raise only \$57 billion a year—or \$24 billion less than it would cost.

My figures are from the Social Security Administration estimates made last year . . . but their pattern holds true for the bill as revised.

To ensure the comprehensive benefits that the program offers, taxes would have to go up.

Even some of the purportedly cost-cutting features of the Kennedy plan could bring an increase in costs. Such could be the effect of the HMOs that it envisions on a massive scale.

Experimental HMOs

If HMOs serve as large a public as they would be expected to serve, their proportion of large, low-income families and high risks could make them insolvent.

Where would insolvency lead? If federal trends of the past four decades are any clue, the HMOs would be bailed out through taxes . . . but still be hard put to provide adequate service.

The AMA has called for caution toward HMOs, pending the outcome of the HMO experiments being funded by the Administration. That call has been heard. We seem to have aborted the vast programs to entrench HMOs as the primary-care delivery system for America. We believe Congress will settle for a mere supplementation of the experimental projects.

Critics of organized medicine might ask: What is our alternative to HMOs as a way to make health care more accessible to more people?

Your society and the AMA have many practical answers to such a query . . . and some of them are already in the works.

They include our joint efforts to place more health personnel and facilities in underserved communities . . . our role in restoring the family physician as the backbone of medicine . . . our programs of consumer health education.

State medical societies are showing remarkable ingenuity in fashioning health-delivery programs that fit their local conditions. They are cooperating with rural clinics and outreach programs radiating from central hospitals and medical schools. They are hastening the day when outlands and central facili-

ties will be linked by computer-related technology, flexible transportation, and appropriate personnel.

The AMA applauds and supports such efforts . . . because better access primarily will emanate not from the think-tanks of Washington . . . but from the localities and states where the problems exist.

Recognizing that emergency care is the lifeline of medical access and that it needs to be upgraded in 80 per cent of U.S. communities, the AMA has introduced a bill to standardize, enhance, and extend it.

The bill would create an Emergency Medical Services Administration within HEW. Its director—appointed by the President—would allocate funds to the states for community distribution on a matching basis. To qualify for the assistance, states would submit a plan covering such points as equipment, communication, staffing, and personnel training.

Bills as wholesome and agreeable as this one seldom get the attention they deserve. So I ask you to help us get it noticed and passed. Your state needs this bill. All states do.

Another of the AMA's bills would create a U.S. Department of Health—headed by a cabinet-level Secretary of Health . . . and administering all health-related programs that are now under the jurisdiction of HEW. Health deserves the focus of a special department . . . just as agriculture, labor, and commerce do.

Again . . . I urge your help in getting the bill recognized and passed. Proper status for health matters on a federal level could be advantageous on a state level.

Unity for Effectiveness

In all that I have said, I have tried to make it plain that action on many of the issues calls for interaction between us.

I repeat what I said earlier: that while we may not always talk in unison, we must have unity.

We must be a cohesive and coherent force . . . in dealing with not only the power of government but the needs of society. If we belittle those social needs, we belittle our own significance.

Our unity must be guided not simply by the desires of the moment . . . but by a conscientious concern for the future of medicine in a changing America.

Inevitably, I come to the issue of physicians' unions . . . to the nature and degree of unity that they would represent.

The AMA Board of Trustees is assessing the union development . . . expects to make a report at our annual meeting in June. Until we take an official position, I shall pass no judgments . . . but I do feel free to raise a few pointed questions.

First, does the union movement have the long-

LEADERSHIP / Kernodle

range objectives that befit professional people? Or is it simply an impulsive reaction to the federal ceiling on fees, third-party pressures, and other annoyances? If it is impulsive, would it not create more chaos than unity in our ranks?

Second, could private practitioners—solo or group—legally engage in collective activity to set fees and conditions of service? Or would they be causing restraint of trade, in violation of the Sherman Anti-Trust Act . . . which recognizes concerted effort by employees but not by entrepreneurs?

Third, how could medical unionism enforce its demands—against a nebulous public or whoever else might be its target? Could it do so without a closed shop . . . without resorting to strikes? Could physicians ethically strike . . . neglecting sickness and the fragile thread of life?

Let us accept the word of the union organizers and leaders that they will call no strikes. Still, some of them favor affiliation with the AFL-CIO. What would AFL-CIO physicians do if other affiliates—maintenance men or cafeteria employees, for example—struck a hospital? Would they abide by union traditions and refuse to cross the picket line?

Indeed, could not their honoring of a picket line become a devious way of enforcing their own demands? Could it not alienate—as well as deprive—the public just as much as a strike of their own?

My fourth question is: Might unionism not abridge rather than enhance our personal privileges? Might it not erase our freedom to accept or reject patients . . . our freedom to decide what, where, and for how many hours a day we practice?

Our professional freedom is crucial to our ex-

istence as scientists, humanists, and seekers of new medical truths. Any infringements on it would be tragic . . . whether they come from government or from forces within our own ranks.

Unity should be directed at protecting our freedom . . . not at subordinating it. It should seek to preserve and enhance our role in society . . . not undermine it.

Increasing Membership

One might reasonably ask: How unifying a force is the AMA? Has it not been hurt by loss of membership?

I have a happy answer. AMA membership, after a drop two years ago, has rebounded. I am confident that this year's final figures will show an increase.

I credit the gain not only to what we at AMA have done. The lively interaction between the national and state associations helps keep the AMA vital and effective . . . and thus attractive to physicians.

Let us apply our common energies to Medigap, broader delivery of care, and other common goals . . . because *where* we go is crucial to *what* we will be.

In serving the public interest, we also serve our enlightened self-interest. The more we do on our own to solve the public issues of health, the more we relieve the public pressures on our profession . . . and thus the threat of governmental coercion and control.

The better we serve the public welfare, the better we serve our own.

This is the kind of road to take.

This is the kind of leadership to give.

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HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

June 25, 1973

Headquarters Office Building: Approved initiation of legal action in tax litigation case to reduce tax assessment of MAG building with request for Council authorization in September.

Mental Health Conference: Authorized MAG co-sponsorship along with AMA and five southeastern states of Conference of Mental Health Representatives in September, 1973.

Appointments: Committee on Education—Curtis Carter, M.D., Augusta, and Victor Moore, M.D., Augusta; chairman, Committee on Annual Session—Preston Ellington, M.D., Augusta; to Georgia State Depart-

ment of Offender Rehabilitation Advisory Committee—Edward Waites, M.D., Decatur.

PSRO Seminars: Approved planning for PSRO informational seminars to be scheduled for Atlanta, Augusta, Columbus, and Savannah with request to Council for funding.

Georgia Medical Care Foundation: Received report on development of Foundation—Medicaid contract for Nursing Home on site review and CHEC (Certified Hospital Extension of Care) Program.

EMCRO: Received report on acceptance by Piedmont Hospital as first test site for EMCRO's Hospital Abstract System.

Diarrhea and a "Shaggy" Polyp in the Colon

CHARLES ANDERSON, M.D. and JOHN T. GIUFFRIDA, M.D., *Atlanta**

DR. CHARLES ANDERSON: This is the case of a 50-year-old female with a history of several months diarrhea without bleeding. There is a past history of hemigastrectomy as treatment of peptic ulcer disease and cholecystectomy for chronic gallbladder disease. There were no other significant symptoms or physical findings. The patient was referred for barium enema examination. Dr. Giuffrida, will you comment on the barium enema?

Barium Enema Films

Dr. John T. Giuffrida: The films of the barium enema demonstrate the entire colon to be filled, including the terminal ileum. There is a constant filling defect in the sigmoid colon (Figure 1). There are other filling defects seen in the transverse colon which are variable and apparently represent fecal residue, however the lesion in the sigmoid colon appears fixed to this area. The post-evacuation film again demonstrates the defect in the sigmoid colon and there is satisfactory evacuation of the enema ruling out any significant obstruction. Multiple diverticula are present in the transverse colon.

The mass lesion in the sigmoid colon presents irregular margins. A lesion such as demonstrated here should suggest foreign body, inflammatory disease, or neoplastic lesion. The presence of diverticula would suggest the possibility that this lesion represents diverticulitis, however, the lack of rigidity and the absence of fistulous tracts which is often associated with diverticulitis would rule out this possibility. I feel that this most probably represents some form of neoplastic disease. This appears to represent a broad-based polypoid lesion with irregular margins. One should think of villous adenoma or polypoid adenomatous carcinoma of the colon. The patient's

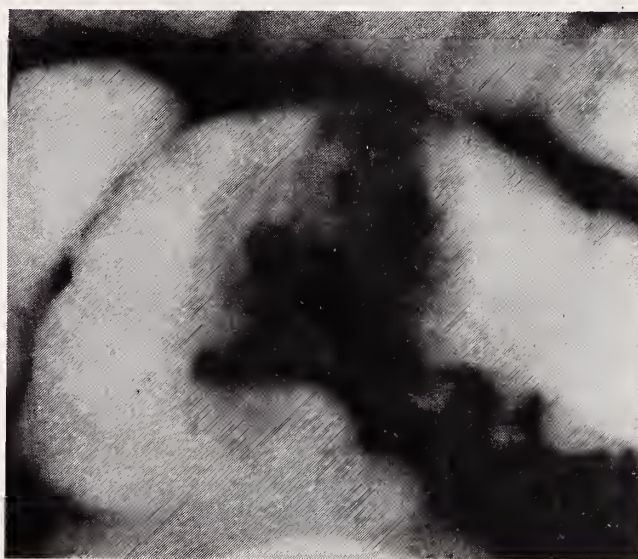


FIGURE 1

Spot film of the sigmoid colon demonstrating the irregular filling defect which has irregular margins. Diverticula are also present in this area.

age of 50 years would rule out the possibility that this represents juvenile type polyp.

Dr. H. S. Weens: Could this represent carcinoid tumor?

Dr. Giuffrida: Carcinoid tumor may assume this appearance, however, this would be a quite rare occurrence. It would seem unlikely that this represents intramural type tumor such as: lipoma or leiomyoma since these tumors are submucosal in location and the intact mucosa over the intramural mass would present smooth margins. The margin of this lesion has a very fine irregular "shaggy" appearance. I feel that this most likely represents villous adenoma. A broad-based polypoid adenocarcinoma is a second possibility. The treatment of either of these lesions would probably be the same in view of the malignant potential of villous adenomas.

Dr. Anderson: What about endometriosis?

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

Dr. Giuffrida: That is a possibility; however, this condition usually presents in younger females.

Dr. Hanes: What about diarrhea with villous adenoma vs. adenocarcinoma?

Dr. Giuffrida: I believe that diarrhea could be a fairly constant symptom associated with either of these conditions. Villous adenoma produces a large amount of mucus and mucinous products. Patients with villous adenoma can lose a large amount of potassium and, in some cases, develop electrolyte imbalances.

Dr. Weens: There seems to be two roentgen patterns of villous adenomas. The more characteristic form is a very soft tumor mass with irregular, fine, delicate folds with barium trapped between the irregular folds. The other type is more polypoid which would fit the pattern demonstrated here.

Dr. Anderson: The patient underwent left colectomy and the lesion did, in fact, represent villous adenoma (Figure 2). There was evidence of adenocarcinoma in its base.

Comment

The benign epithelial tumors of colonic mucosa can be divided into two categories. These consist of the more common adenomatous polyp and the less frequently encountered villous adenomas. Villous adenomas, although they may occur anywhere in the colon, are most often found in the sigmoid and rectum. They comprise about two per cent of all neoplasms found in the colon and rectum. The tumors are encountered much more frequently in the elderly, their peak incidence occurring in the sixth, seventh and eighth decades.

Villous adenomas vary in size from 2 cm. to an extremely large mass which completely encircles the bowel. The larger ones may extend for a distance of 15-20 cm. or more. The tumor is usually a spongy, sessile mass with a broad base. It is characteristically red or reddish gray in color. They consist of a complex system of branching, finger-like villi which are joined at their bases in a lobulated pattern. These soft, friable villi are covered by a mucus-producing epithelium. In combination, they create an extensive surface area which accounts for the enormous amount of mucus lost from the colon. This also accounts for the frequently encountered loss of considerable amounts of protein and electrolyte depletion.

There is a strong tendency towards malignant degeneration among villous adenomas, although this characteristically occurs late. It is generally accepted that the larger the lesion is, the greater is the possibility of malignancy being associated. Many contain only small areas of carcinoma in situ as evidenced



FIGURE 2

The gross specimen of the excised lesion from the sigmoid colon. Histologically this represented villous adenoma with evidence of adenocarcinoma at the base of the lesion.

by intra-glandular bridging or budding with associated nuclear atypia.

Common Presenting Symptoms

The most common and characteristic presenting symptom is that of a profuse discharge of large amounts of mucus from the rectum. Often the mucus is passed separately from the remainder of the stool. Other common presenting symptoms include rectal bleeding, change in bowel habits, tenesmus, diarrhea, abdominal pain, constipation, weight loss, and a feeling of incomplete evacuation.

The barium enema roentgenographic findings are characteristic and should provide the surgeon with the diagnosis preoperatively. A sharply demarcated polypoid, intra-luminal defect is produced. In all cases, there is no obstruction to the retrograde flow of barium and no obstruction to evacuation is produced. The characteristic appearance is that of a lace-like reticular pattern produced when the barium becomes dispersed among the numerous branching villi. There has also been described a multiplicity of irregular filling defects, which when seen en face produce a cobblestone or bubbly appearance which are polypoid in appearance. The pattern is best seen on post-evacuation or air-contrast films. Characteristically, the tumor appears reduced in size on the post-evacuation film and appears to have a rough, feathery, serrated margin.

Emory University School of Medicine 30322

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This type of service can be a great asset to the overall health care in a geographic area.

A Genetic Counseling Clinic in a Community Hospital

RODNEY M. BROWNE, M.D., *Macon*

THE PURPOSE OF THIS presentation is to recount the experiences of a genetic counseling unit in a community hospital setting at the Medical Center of Central Georgia in Macon. This hospital serves 29 counties in central Georgia with 26,000 admissions annually, including 3,200 deliveries.

This program was initiated in July 1970 as a joint project of the National Foundation, Middle Georgia Chapter, and the Macon Obseterical Society. In June 1970, an explanatory letter was mailed to all middle Georgia physicians announcing the inception of this service.

From July 1970 to July 1972 the counseling was termed a Genetic Service and all work was carried out by telephone and letter. This soon proved unwieldy and in July 1972 the structure was changed to a Genetic Counseling Clinic with monthly sessions, an office in the Medical Center of Central Georgia, and more direct patient contact.

The remainder of this presentation will be concerned with the format of our counseling arrangement and a brief summary of the genetic problems encountered.

Counseling Format

Patients are referred by private physicians, house staff, or the Public Health Department. A history is obtained from the referring physician to expedite the counseling process. The secretary arranges appointments, gathers preliminary information, and instructs patients in clinic procedure. The details of the counseling process will be presented later.

Physical facilities for the clinic are provided by the Medical Center of Central Georgia and include waiting area, clinic office, and an available examining room. The furnishings for the office (curtains, carpets, etc.) have been provided by the interns and residents Wives Club, whose national organization has birth defects as its project for the year. The Macon Junior Woman's Club has volunteered to

help with the clinic, and provides a monetary contribution as well as escort service.

The clinic meets monthly. Patients to be seen are first interviewed by the secretary, and then seen by the clinic consultant. The ob-gyn residents are occasionally present for this phase of the process. Appropriate lab studies are ordered, and the couple is given another appointment to return for final advice. After the study is completed, the information is transmitted to the referring physician to complete the process.

Following each clinic session, there is a genetics-endocrine lecture given by the consultant, Dr. Paul McDonough. This is directed as a teaching session to the residents and attending staff. Pertinent clinic cases are discussed for clinical correlation with the didactic lecture.

Patient Followup

Due to the relative infancy of this clinic unit, conclusions concerning its effectiveness must be drawn with care. The data here presented covers the period from July 1970 to January 1, 1973, a span of 30 months. As a result, followup material in the form of a live-born, unaffected infant is scarce. However, some preliminary studies of patient followup are encouraging. We can at least review at this time the input of clinic material, and perhaps at some later time, more detailed followup will be available.

During this 30 month period, a total of 48 couples or patients presented themselves for genetic counseling. They came from eight Georgia counties. Studies have been completed on 36 cases with results pending in 12 cases.

The diagnoses prompting genetic advice are shown in Table 1. The three most common problems, comprising 53 per cent of the total, were multiple congenital anomalies, recurrent abortions, and chromosomal defects.

The benefits from the work of our community

genetic unit fall in several categories:

- (1) Delivery of specialized health care on a local level. This benefits both patient and primary physician and leads to provision of services to patients who might not otherwise have been reached.
- (2) Residency training—the residency program is complemented by exposure of residents to a rapidly developing field of human reproduction. The resident gains first-hand clinical counseling experience, and becomes familiar with counseling resources available.
- (3) Public awareness—there has been a great deal of public interest concerning this project. Since its inception there have been two feature newspaper stories, one radio program and four television programs concerning the Genetic Service. Clinic personnel have delivered lectures on four occasions to interested groups. We feel that public information can lead to awareness of genetic problems with resultant prevention of genetic disease and support of the clinic.

Plans for Expansion

Future plans for the unit call for expansion of services, increased funding, and wider dissemination of genetic counseling information.

Plans call for expansion of laboratory capabilities to include chromosome banding studies and amniotic fluid studies. A request for additional funding from the National Foundation in the form of a national grant will be made.

We have also discussed the involvement of undergraduate students from the three colleges in Macon. These students would receive information regarding practical application of genetic principles and would help with field studies, interviewing, pedigree work, etc.

In summary then, we feel that a genetic unit in a community hospital setting can be a great asset to the overall health care of the area. The primary physician is given an additional source of useable assistance in the management of some difficult prob-

TABLE 1
PRE-COUNSELING DIAGNOSES

Multiple congenital anomalies	7
Recurrent abortions	5
Other trisomies	4
Down's syndrome	3
Harelip, cleft palate	2
Growth retardation	2
Hemophilia	2
Congenital blindness	2
Congenital deafness	1
Tracheo-esophageal fistula, recto-vaginal fistula	1
Anencephaly	1
Gonadal dysgenesis	1
Microcephaly	1
Hydrocephalus	1
RH incompatibility	1
Spina bifida	1
Abnormal calcium metabolism	1

lems. Patients are able to relate directly to people, facilities, and agencies in their local environment. Consciousness of prevention of birth defects by genetic methods is raised to a higher level.

Our limited experience indicates there are several key items necessary for such a unit:

- 1. A consultant—this is surely the foundation of the clinic. Dr. Paul McDonough of the Medical College of Georgia has functioned in an outstanding manner in this position for us. He not only furnishes a high level of genetic expertise, but inspires us with his enthusiasm.
- 2. Cooperation of the hospital administration—this is vital. The Medical Center of Central Georgia furnishes us with space, telephone service, furniture, office supplies, and bookkeeping service.
- 3. Adequate funding—this comes primarily from the National Foundation, but we also receive funds from the Macon Obstetrical Society, Macon Junior Woman's Club and individual donations.

Our limited experience leads us to believe that genetic counseling centers in a community hospital setting are useful, practical, and desirable. If we are to meet the increasing demands for genetic services, more of these centers will be needed in the future.

740 Hemlock Street 31201

MAG MEMBERS APPOINTED TO NEW DRIVERS LICENSE ADVISORY BOARD

Governor Jimmy Carter has announced the appointment of a seven-man Drivers License Advisory Board to consult with the Governor, the Commissioner of Public Safety and the Department of Public Safety on matters concerning driver licensing and highway safety.

Carter cited the need for establishing some standards of mental and physical health and visual ability for the licensing of drivers when announcing the appointments. He directed the Advisory Board to submit recommendations of such standards and of methods for

determining whether or not an applicant meets these standards.

MAG members appointed to the Board include: Fleming L. Jolley, M.D., Atlanta; Thomas N. Lumsden, M.D., Clarkesville; Richard R. Schulze, M.D., Savannah; James H. Smith, M.D., Rome; and August S. Yochem, Jr., M.D., Atlanta. Other members include I. Dell Engram, Jr., O.D., Fairburn and S. Cliff Rainey, O.D., LaGrange.

A research program has been established at the Medical College of Georgia to study this procedure which may offer a solution to many couples.

Sperm Banking

ROY WITHERINGTON, M.D. and A. M. KAROW, JR., Ph.D., Augusta

MODERN METHODS FOR SPERM cryopreservation are simple, inexpensive and convenient. Men might desire to have sperm banked prior to having elective vasectomy or prior to undergoing therapeutic procedures of one sort or another that might render them sterile. It also provides a source of sperm for couples desirous of having their own babies, but where the husband is unable to beget children.

Storage Methods

Ejaculated semen, collected in a clean dark glass or opaque plastic container, is allowed to liquefy by standing for about 30 minutes. The semen is kept covered during this period of time since sperm are photosensitive. A routine semen analysis is then performed. It is advisable to utilize good high quality semens for cryopreservation. The cryoprotectant clinically used for human sperm is glycerol. One part glycerol is added to 12 parts semen to achieve a final glycerol concentration of 7.7 per cent. The diluted semen is aspirated into a plastic paillette (a container resembling a plastic drinking straw) and the ends of the paillette are sealed. The paillettes are then placed in a refrigerator at 4° Centigrade for 30 minutes allowing the semen to cool slowly, thus preventing thermal shock. Freezing is then accomplished by removing the paillettes from the refrigerator and suspending them over the surface of liquid nitrogen so that the temperature falls at a rate in the range of 25° Centigrade per minute.

Maintaining the frozen sperm in liquid nitrogen storage poses no significant problem. Frozen sperm may be shipped either in a container of liquid nitrogen or on dry ice in highly insulated corrugated cardboard boxes.

When frozen sperm are needed for insemination, a paillette is removed from the liquid nitrogen and dropped into water until all the ice has disappeared. A drop of thawed semen is then examined to determine the degree of sperm motility. Frozen and

thawed sperm lose some of their fertilizing capacity and viability, as well as motility.

Pregnancies are achieved at about one third the rate possible with fresh semen. Nevertheless, 520 births from frozen stored human semen have been documented. One of these children is now 19 years of age and in apparent excellent health mentally and physically. In this series of 520 children, five abnormal children were born (less than 1 per cent) which is less than the general figure of 6 per cent abnormal children for the population at large. The longest period of cryopreservation of fertility exceeds 10 years.

MCG Research

At the Medical College of Georgia, the Department of Pharmacology and the Urology Section have established a sperm bank for research purposes to study and evaluate frozen human sperm in artificial insemination. The evaluation of patients for sperm banking is carried out by the Urology Service and the technical aspects of sperm cryopreservation are carried out by the Department of Pharmacology. Sperm are frozen for patients to the best of our ability according to professional standards but we cannot be held professionally responsible for progeny (or the lack of progeny) resulting from the use of frozen sperm. We do not discourage the use of frozen sperm and patients seeking the benefits of frozen sperm should be advised that it is a research effort undertaken to help answer the many unknowns about frozen sperm.

The patient is advised to bank three ejaculates, these being produced every 48 hours with abstinence otherwise. A reasonable fee is incurred for the clinical evaluation and technical services initially. Thereafter, there is an annual storage fee which is necessary to underwrite the cost of storage equipment and liquid nitrogen.

Medical College of Georgia 30902

*The surgeon has a key role in helping
the patient adapt to his new
situation.*

The "Average" Ostomy Patient

LAWRENCE P. DAVIS, M.D., *Augusta**

IN AN ATTEMPT TO DETERMINE problem areas in the life of an ostomy patient, a questionnaire survey was sent to all of the patients undergoing this type of surgery at Eugene Talmadge Memorial Hospital since 1965. Approximately 25 per cent of the total 467 patients responded. The questions, which probed medical as well as personal subjects, led to the formulation of what a typical colostomy, ileostomy or ileal conduit patient was like at a teaching referral hospital. It should be noted that although we do receive many trauma patients, the bulk of our admissions are indigent referrals from the state of Georgia with nontraumatic etiologies.

A typical colostomy patient was a 53-year-old white male Protestant who was admitted for carcinoma or "tumor." Excluding birth defects and trauma he spent a total of three and a half weeks in the hospital before operation (this may have been more than one admission). He had a little more than three weeks notice that he would have an ostomy operation. The time interval between ostomy operation and return to work was one year and four months. This patient usually had another operation in the interim before returning to work. Over half of the reoperations were closures of ostomies.

Typical Ileostomist

The ileostomist was a 29-year-old man or woman (sexes equally divided) whose operation was for ulcerative colitis. Although 10 per cent were Jewish, the typical patient was still Protestant. He spent a total of 45 days of hospitalization before operation and was given a little less or about six weeks notice that the operation would be performed. The ileostomy patient returned to work one month after this original procedure. His perineal wound required an average of eight weeks to close.

The patient with an ileal bladder was a 31-year-old black or caucasian Protestant (races equally divided). Although very close, males predominated over females. The etiology behind the diversion pro-

cedure was either trauma or long standing infection of the genito-urinary tract. Over three years elapsed before return to work (this figure may be difficult to evaluate because of the large number of plegic patients in this category).

Questions asked all ostomy patients, regardless of type, revealed the following facts about our "average" patient. He was in some married category (married 29 per cent, widowed 18 per cent, separated 10 per cent, divorced 6 per cent) before operation, and surprisingly this status did not change postoperatively. He was a full-time employee preoperatively, but trended to nonworking categories after operation (both full and part-time student categories increased as did homemaker and retired personnel).

Our ostomy patient (83 per cent) had never worked with a counselor, psychologist or ostomy club member, although the local ostomy association was organizing at the time of sending out the questionnaire.

Problem Areas

One out of three ostomates had had trouble with their appliance, skin around stoma, control of bowel sounds or odors. When asked to rank these individual problems; acceptance of the ostomy, routine care and travel seemed to be priority areas. Sexual adjustment and sports were given as least problematical.

The physician (as opposed to surgeon) was ranked highest as the person who most helped prepare the patient for the operation. Husband or wife took this distinction for help after surgery. The surgeon ranked second in both lists (pre and post-op).

Finally, the ostomy patient generally considered himself in less than optimal health at the present time (67 per cent in fair or poor categories). Nevertheless, 52 per cent did not consider themselves handicapped in any way on another question.

In summary, the average ostomy patient at our institution was defined with trends in certain areas of personal problems identified. Further studies will attempt to more clearly define these areas of concern.

Medical College of Georgia 30902

* Resident in surgery, Medical College of Georgia, Department of Surgery, Eugene Talmadge Memorial Hospital in Augusta.

Electrical Stimulation for the Nerve Deaf Person?

LESTER A. BROWN, M.D., *Atlanta*

More and more articles are appearing in the public press, usually in syndicated columns, on the subject of electrically stimulating the hearing nerves so that those people with so-called nerve deafness can regain their hearing. Mothers of congenitally deaf children are cheered by the thought of their deaf offspring being able to lead normal lives. Almost daily, nerve deaf persons call their physicians for further information. These people have the impression that this procedure consists of applying something to the head like the beauty parlor hair dryer which would charge or recharge the failing organ. Unfortunately, this is neither a brand new idea nor presently a workable one. The first attempts were unsuccessful 40 years ago.

On June 10 and 11, 1973, at the University of California Medical Center in San Francisco, under the direction of University of California Chancellor Francis A. Sooy, M.D., "The First International Conference on Electrical Stimulation of the Acoustic Nerve as a Treatment for Profound Sensorineural Deafness in Man" attracted some 300 ear practitioners, researchers, and professors from over North America and many foreign countries.

The following are a few of the gleanings:

(1) This work is being done in greatest concentration at three medical centers in California.

(2) Only persons who have had hearing and lost it are eligible for consideration. They must be able to talk. These persons must be "profoundly" hard of hearing (otologic parlance for the layman's "totally deaf").

(3) Statisticians compute that there are about 70,000 eligibles in the United States.

(4) The procedure involves a team effort of ear specialists, an electroacoustical engineer, hearing and speech experts with the ultimate in knowledge of testing the capabilities of the hearing nerves and teaching the patient to become adapted to the new sounds that come into the ear through a type of implanted hearing aid which has its terminal wires actually inserted into the hearing nerve by way of the most complicated ear operation ever concocted. Every facet of this unbelievable procedure is plagued by situations, some of which were not even thought of prior to their appearance.

(5) Not all the equipment has been perfected.

(6) Even after a person has been found to be a (questionably) suitable candidate and has had the operation, he must spend half a day per week, or more, for an indefinite time, in the Center's laboratories.

(7) Of the very few surgically treated deaf people, not one, and I repeat, *not one* has been returned to normal hearing.

(8) The technical routine has not become standardized.

So, while there is not an optimistic note for the nerve deafened at the moment and researchers don't agree on the future in light of the present, we do have one thing: there is a large amount of work being done by teams of dedicated people.

490 Peachtree Street, N.E. 30308

WISH YOU KNEW MORE ABOUT FAMILY PLANNING? TRY THIS

Physicians in all specialties are being offered two-day family planning clinical courses designed to give them a background on the types and uses of contraceptive methods and skills in performing physical examinations.

The course, held each month through the remainder of the year, is given by the Regional Training Center for Family Planning, the training facility for the Emory University Family Planning Program. Jules S. Terry, M.D., M.P.H. is director of the training center. The American College of Obstetricians and Gynecologists (ACOG) offers a stipend of \$26 per day to physicians attending the course.

Upon completion of the course, it hoped that each participant will be able to: 1) enumerate the indications, methods of use, complications and use-effective-

ness of each contraceptive method; 2) perform a physical examination which would include breast examination, teaching the patient in the techniques of self-examination, abdominal examination, visualization of the cervix including Pap and venereal disease smears, bimanual pelvic examination and rectal examination; 3) prescribe oral contraceptives according to guidelines; 4) insert an IUD; and 5) give an account of three experimental contraceptive methods.

Physicians wishing to apply for the course should write to the Regional Training Center, Emory University Family Planning Program, Hartford Building, Room 805, 100 Edgewood Avenue, N.E., Atlanta, Georgia 30303.

MAGNET '73

Communicating

Medicine's

Story

The cover of this month's Journal depicts a montage of communications vehicles. It is also illustrative of how complex we have become in our approach to transmitting messages between nations or even individuals.

With all our sophistication, we still have difficulty being heard, and being understood is often completely out of the question. How many times have you had to re-explain medication instructions to a patient or spent too much time in dialogue with a department store over whether to connect you with first floor knives and forks or sporting goods? Perhaps not germane examples but similar to ones we have experienced as consumers.

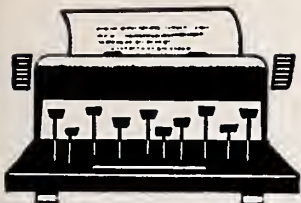
This year, through MAGNET '73 we will explore many effective ways to communicate both with individuals and groups plus some insight on how the news media views doctors in Georgia.

For these program parts we have lined up a cast of professionals headed by **Harry Schwartz**, editorial writer for the New York Times and author of The Case for American Medicine. Also participating will be **Frank Campion**, Communications director of the AMA and **Mort Enright**, director of the speakers and leadership programs of the AMA.

On Sunday we will tackle the hottest issue to hit the medical profession in years—PSRO. Our PSRO presentation will be headlined by **Robert B. Hunter, M.D.**, recently appointed to the national PSRO Council.

This is just a sampling of our MAGNET '73 program. A complete program and registration form will be sent to you in the near future.

MAGNET '73 will be held November 3-4 at the new Atlanta Internationale Hotel across from the Stadium. The program is one you won't want to miss so mark your calendars now. MAGNET is open to all MAG members with special emphasis placed on the involvement of new county society officers and new members.



Accreditation Program Given Approval

THE AMERICAN MEDICAL ASSOCIATION'S Council on Medical Education has provisionally approved MAG's Continuing Education Accreditation Program. The MAG Committee on Education's Task Force on Continuing Education initiates its surveys with Piedmont Hospital in September.

The MAG will conduct this voluntary accreditation program for community hospitals and other organizations providing continuing education for physicians. The MAG will concentrate its program on 1) local hospitals which have continuing medical education activities limited to hospital staff and physicians in the local community; 2) medical organizations of state or local scope; 3) local units of voluntary health organizations; 4) other state or local organizations and institutions which sponsor or promote continuing education for physicians, appropriate to the needs of the profession.

Institutions or organizations accredited will be eligible for similar accreditation by the AMA upon recommendation of the MAG Committee on Education.

The initiation of this accreditation program comes as another step in recognizing the importance of continuing education for physicians. As professionals, responsible for the health and oftentimes the lives of patients, physicians through their hospital medical staffs, specialty societies and county medical societies have had the opportunity to voluntarily maintain their competence as medical practitioners.

After identifying and documenting CME programs which can be accredited, the MAG will endeavor to work with those programs and assist in the development of others to assure that they meet the needs of physicians and that they assist in maintaining the high level of the quality of medical care in Georgia.

Inquiries regarding accreditation for hospitals, other institutions and organizations should be addressed to the Task Force on Continuing Education, Committee on Education, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.



Medicine's Maze Frustrates Patients

ONE OF THE MOST COMMON complaints I hear from my patients, friends and relatives concerning medical care is not how much we physicians and hospitals charge for our services, but rather the fact that so often the procedure for obtaining proper or quality medical care is so complex that the patient becomes frustrated, then resentful and finally downright angry with the entire medical profession. This is the type of thing that leads a previously friendly, docile, happy patient to bring suit against a well trained and competent specialist because of some minor or perhaps even imagined bit of medical wrongdoing.

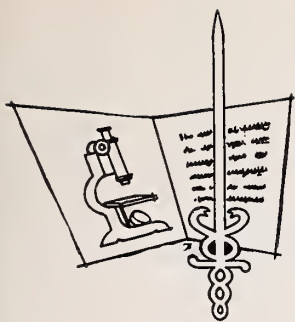
Recently a minor female injured her knee playing basketball at a junior high school in a large city. Her parents immediately called the child's pediatrician. This physician informed them over the phone that he did not treat orthopedic problems. He did not offer to examine the child or to obtain orthopedic consultation. He gave them the names of two orthopedists and told the parents to call. Neither of the two would see the child on that day. After a painful and sleepless night the child was carried to an emergency room and there directed to an emergency orthopedic clinic where finally she obtained proper and high quality care for her hemarthrosis.

You ask who is at fault. We all are. The primary physician should direct the patient through the often complicated maze that leads to the desired end results. The specialist must be ready and willing to accept the patient. There must be cooperation and mutual understanding between physicians involved in the various levels of care and at the same time all must strive to keep the patient informed and contented. Though many of us are highly trained in narrow fields of medicine, we are all physicians first and specialists second.

In the eyes of our patients we are physicians, people to be respected. A physician who is unconcerned, garrulous or detached when his patients are seeking his assistance not only loses the respect of his individual patient, but also damages the image of all his colleagues. There is a rotten apple in every barrel, and all those in contact with it smell as it does . . . rotten!

A handwritten signature in cursive script, reading "Charles E. Bohler, M.D.".

Charles Emory Bohler, M.D.
President, Medical Association of Georgia



THE POSTMASTECTOMY LYMPHEDEMATOUS ARM

GUY F. ROBBINS, M.D. and WILLIAM M. MARKEL, M.D., *New York**

POSTMASTECTOMY LYMPHEDEMA CAUSES serious problems in less than 10 per cent of patients. Yet, when it occurs, lymphedema is a distressing and sometimes disabling burden for the patient and a challenge to the physician. Controversy continues regarding etiology and treatment programs vary. However, it is agreed that the prevention of the postmastectomy edematous arm is far more valuable than any valiant surgical or medical procedure designed to remedy the condition once it has occurred.

Etiology

An often confusing array of etiologic factors have been advanced to explain the development of lymphedema. Prime factors appear to be: (1) unusual trauma of the axillary vessels during surgery; (2) postoperative infection of the axillary area; and (3) fibrosis following radiation therapy. Postoperative infection, signalled by localized induration and occurring even years later, as the result of burns, cuts, insect bites, severe bruises of the hand, arm and forearm, hypodermic or intravenous injection or vaccination may either initiate the process or increase the severity of pre-existing lymphedema.¹

Regardless of the specific etiology, the mechanisms producing lymphedema are essentially the same: the lymph flow from the extremity is blocked causing an increase in hydrostatic pressure. This increase in pressure leads to dilated lymph vessels and incompetent lymph valves. At the same time, there is an increase in the protein content of lymph and proliferation of fibroblasts in the tissues. And, since a lymphedematous extremity is an excellent culture medium for bacteria, resultant infection may lead to thrombosis of the lymph vessels and further blocking of lymph flow, increased lymph stasis and progressive fibrosis of the connective tissue.

Prevention Begins at Operation

Preventive measures begin at the time of operation. Careful handling of tissues during the surgical procedure and the development of an incision that will not close directly over the axillary bundle are advised. Also, care should be taken not to disturb the clavicular portion of the pectoralis major muscle since it will provide a shelflike roof for protection of the proximal portion of the axillary vein. To prevent injury to existing structures, vein thrombosis, infection or the formation of excessive cicatrix, it is important that the physician: (1) use a sharp dissec-

* Dr. Robbins serves as acting chief, Breast Service, Department of Surgery of Memorial Hospital in New York City and is on the National Board of Directors of the American Cancer Society. Dr. Markel is Vice President, Service and Rehabilitation, American Cancer Society.

tion thus avoiding the necessity for mass clamping or mass ligation; (2) handle the axillary vessels gently and carefully ligate the tributaries of the axillary vein; (3) use fine suture material. Primary skin grafting may help avoid incisional scars over the axillary vessels. Specific operative procedures designed to avoid postmastectomy edema have been described by various physicians.²

Another important aid in the prevention of lymphedema is the maintenance of gravity drainage following surgery through elevation and partial abduction of the extremity. The patient's fingers and hand are raised higher than the forearm and the forearm higher than the pillow. Since this position cannot be maintained for the optimum period of six weeks, elastic compression bandaging from finger tips to shoulder is highly recommended for six weeks following surgery. Active motion and graduated exercises beginning on the first postoperative day are also helpful.³ However, such exercises are not indicated when skin grafts have been used or when the patient has been subjected to a radical mastectomy and chest wall resection.

Patients Prevent Trauma

It is essential that the postmastectomy patient be instructed on the various measures to prevent trauma which may lead to impaired lymphatic and vascular circulation. The following written list of "dos and do nots" should be given to patients upon discharge:

1. Push cuticles back—do not cut—avoid possible infection.
2. Wear canvas gloves when gardening; wear rubber gloves when cleaning pots and pans with steel wool.
3. Wear padded gloves when reaching into oven. Avoid burns.
4. Keep watch band and jewelry loose on operative arm.
5. Keep dress sleeves loose. Avoid pressure and swelling.
6. Use unaffected arm to carry heavy purse and packages.
7. Use unaffected arm for blood pressure readings, injections, vaccination, etc.
8. Wear thimble when sewing.
9. Wash the smallest break in the skin on operative side, immediately with soap and water, and cover with a band aid.
10. Use electric razor for shaving and avoid nicks and scrapes.
11. Do not get sunburned; get tanned gradually.
12. Contact doctor if arm on operative side feels hot, is reddened or swollen.
13. Hold cigarette in the unaffected hand—avoid possible burns.
14. Keep arm elevated when sitting; do not let arm hang down by side.

Frequent follow-up is necessary to keep the patient mindful of the need for preventive action. The use of a fitted elastic sleeve and/or one of the available units which apply controlled pressure is practiced by many clinicians and although these procedures can be useful, in-depth scientific evaluation of these products is not available.

Treatment

Despite preventive measures, approximately 10 per cent of postmastectomy patients develop lymphedema. Present-day chemotherapy has been helpful when infection is present; surgical procedures reported in the literature designed to re-establish lymph flow generally result only in a modicum of success. However, there is recent, encouraging data on the control of postmastectomy lymphedema by the transposition of the partially detached omentum beneath the superficial tissues of the chest wall to the axilla and upper arm.⁴

Nevertheless, it appears that for the present we must consider some kind of mechanical means to overcome the obstruction of fluid flow. Elastic sleeves are

frequently helpful although they may be uncomfortable for the patient and they are sometimes cosmetically unacceptable. A pressure pump may be helpful in special instances under medical direction. However, if there are signs of lymphangitis (redness and streaking of the arm, with or without accompanying fever) manual manipulation of the arm is contraindicated.

Because of the prevalence of infection, some physicians give antibiotics prophylactically to all patients with postmastectomy lymphedema.⁵ Antibiotics are advised in the acute phase of lymphangitis, for long-term treatment during the chronic phase, if there is any necrosis of the wound margin or fluid beneath the wound flap.⁶ A low salt diet may help, at times, and the administration of dehydrating agents has been of limited assistance.

Summary

Postmastectomy lymphedema is a distressing and sometimes disabling complication which causes serious problems in less than 10 per cent of patients. All available preventive measures should be utilized since medical and surgical procedures are not very effective once the entity has occurred. The use of elastic sleeves and pressure pumps may be beneficial. Antibiotics are indicated in the acute phase of lymphangitis and for long-term treatment during the chronic phase, if there is any necrosis of the wound margin or fluid beneath the wound flap. A low salt diet and the use of diuretics may also be of assistance.

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18 MILLION VOLT LINEAR ACCELERATOR BOLSTERS CANCER THERAPY

A new machine for radiation therapy of cancer patients is being installed as part of an expansion project at the Emory University Clinic. The machine—a linear accelerator operating up to 18 million electron volts—is said to be the largest of its kind in the Southeast to be used in a clinical application.

The linear accelerator will be used for selected cases of cancer and will permit increased patient loads for cancer therapy because of its high radiation output per minute. Other advantages of the unit are a sharper, better defined beam of radiation and the capability for treating larger areas of the body more rapidly and easily. In addition to the high energy x-ray beam, an electron beam is available to treat areas where underlying vital tissues should be spared.

The new equipment will give the Clinic a very broad

range of capabilities for cancer therapy, according to John R. McLaren, M.D., head of radiation therapy at the Clinic. Already in use are a Betatron of 25 million electron volts; two cobalt units, each with a 2 million volt potential; and two x-ray therapy machines, one of 250,000 and the other of 130,000 volt potential. Adequate supplies of radium or equivalent sources for radiation are also available, Dr. McLaren said.

The expansion program involves a \$3.8 million addition to the east wing of the Scarborough Memorial Building which houses the Emory University Clinic. Facilities for radiation therapy are in the Robert Winship Memorial Clinic, which is devoted to the study and treatment of cancer. The Winship Clinic is an interdepartmental group within the Emory University Clinic.



SHOULD MILD SYSTEMIC ARTERIAL HYPERTENSION BE TREATED?

SAMUEL D. RAUCH, JR., M.D., *Atlanta**

THE VALUE OF TREATING mild systemic arterial hypertension has been questioned by many physicians. Although hypertension is commonly associated with many other cardiovascular diseases, until recently one could neither be sure that mild hypertension caused other cardiovascular diseases nor that treatment of hypertension prevented them. Potential side effects of drug treatment in addition to possible economical and psychological burdens for the patient caused further concern that treatment of hypertension, especially mild hypertension, might not always be in the patient's best interest.

Five Year Study

Several studies over the past five to ten years have conclusively shown that treatment of mild to moderate hypertension is worthwhile. The course of untreated hypertension and the results of therapy have been examined prospectively with controls over the five year period 1964-1969 by the Veterans Administration Cooperative Study Group on Antihypertensive Agents.

Of 194 male patients who had sitting diastolic blood pressures of 90-114 mm Hg during hospitalization and who were treated with placebo, 55 per cent developed morbid events during the five year period. Only 18 per cent of 186 patients with similar blood pressures developed morbid events when treated with a combination of 100 mg hydrochlorothiazide, .2 mg of reserpine and 75-150 mg apresoline daily.¹ Morbid events included death due to cardiovascular disease as well as non-fatal cerebrovascular accidents, congestive heart failure, accelerated hypertension and progressive renal damage. In the placebo-treated group there were five deaths from hypertensive-related cardiovascular disease (dissecting aortic aneurysm, intracranial hemorrhage) and 14 deaths from other cardiovascular disease (myocardial infarction, cerebral thrombosis, sudden death).

In the drug-treated group no deaths occurred from hypertensive-related cardiovascular disease and only eight deaths from other cardiovascular disease. Thus, the natural course of mild "benign" hypertension is not benign since over half of the untreated patients can be expected to have some severe cardiovascular event in five years or less. Treatment appears to be effective in both lowering the blood pressure and significantly lessening the chances of complications.

Effectiveness of therapy (per cent reduction in expected number of morbid events) was 35 per cent in patients with diastolics of 90-104 mm Hg, 75 per cent with diastolics of 105-114 mm Hg and over 90 per cent with diastolics of 115-129 mm Hg. Drug toxicity was not a serious problem in these studies. The incidence of depression and peptic ulcer was low and was almost equal in the drug and placebo-treated group. Two of the 186 actively treated patients had to be withdrawn from the study because of reversible but recurrent drug reactions.

Unfortunately, some important questions remain unanswered. Randomization

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association. Dr. Rauch is a Fellow in Nephrology and Inorganic Metabolism, Department of Medicine, Emory University School of Medicine.

of patients was based on pressures after four days in the hospital. Since hospitalization of new hypertensive patients usually is not feasible, physicians must use serial outpatient blood pressures in predicting morbidity and assessing therapy. One still is not sure at what point in the range of diastolics from 90-100 mm Hg it would be best to institute therapy. The management of labile hypertension remains controversial. If not treated, labile hypertension should at least be followed periodically since it is a frequent precursor of fixed diastolic hypertension. We do not know how completely hypertension in an individual patient must be controlled to prevent complications. These unanswered questions should not detract from the overriding conclusion that a more vigorous approach to hypertensive therapy is justified.

The implications of this study are somewhat disturbing. One cannot ignore the fact that many unidentified and some identified but untreated hypertensive people would benefit greatly from treatment. The obese hypertensive patient, for instance, should not have antihypertensive drug therapy delayed unless weight reduction is prompt and effectively lowers the blood pressure. A patient admitted for elective surgery and discharged without treatment or follow-up for mild hypertension may have lost his only chance for therapeutic intervention.

Screening Programs

Undetected hypertension presents a different set of problems. Previous studies indicate that screening programs will detect hypertension in 10-20 per cent of the adult population and that one-half to two-thirds of these hypertensives will not have been treated.² Many of these people are asymptomatic and will find no occasion to visit a physician until late in the course of their disease. Even after detection some of these patients may not be amenable to therapy; however, in view of the effectiveness of therapy, they should at least have the opportunity to be treated.

Some cities and counties in Georgia have already developed large screening programs. The challenge is to periodically screen large groups of asymptomatic adults, convince the hypertensive ones that treatment is worthwhile and will not interfere with their way of life, develop work-ups that, with minimal laboratory tests and expense, exclude surgically-correctable hypertension (many institutions no longer consider an IVP essential in the evaluation of all hypertensive patients), and arrange readily acceptable treatment regimens involving as few pills per day and as little expense as possible.

Difficulties in arranging these programs and assuring adequate follow-up for the hypertensive patients identified cannot be minimized; however, models and guidelines are available for any community desiring to undertake this project.² Increased use of physicians' assistants and nurses may be necessary to confirm the presence of fixed diastolic hypertension by obtaining serial blood pressures and to collect initial historical, physical and laboratory data. In the long run, however, it should tax medical resources less to control hypertension than to care for those who become disabled and economically unproductive as a consequence of the disease.

The goal of having the majority of Georgia's hypertensive population identified and appropriately treated remains elusive; nevertheless, we now have a much better idea of who should be treated. The VA study confirms that antihypertensive treatment of patients with diastolic pressures over 100 mm Hg is definitely in the patients' best interest. Although not conclusive, the same evidence strongly suggests that treatment of patients with diastolic pressures of 90-100 mm Hg is also beneficial.

80 Butler Street, S.E. 30303

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CORPORATE DIRECTOR'S LIABILITY

J. WINSTON HUFF, *Atlanta**

PHYSICIANS ARE OFTEN OFFERED, and often accept, positions as directors of business corporations. In some cases, the corporation desires the prestige which the physician's name will give to the public; in other cases, the physician may be an investor in the business. In any case, a directorship should not be taken casually, for it can place the physician in jeopardy of personal liability.

In years past, service on a board of directors was not fraught with too much danger. However, the situation has since greatly changed. Some of the change has been due to changes in statute law. Perhaps more important has been the change in the public's awareness of the personal liability of the director as a target for legal action. In a sense this development has been somewhat like the increasing popularity of medical malpractice claims—the “discovery” that there is an inviting solvent defendant to sue when anything goes wrong. This has resulted in a vastly increased number of lawsuits against directors and a widening body of court interpretation of the responsibilities and liabilities of directors.

It is recommended that a physician give careful consideration to his decision before he agrees to become a corporate director.

A director is by law required to exercise a high standard of care and diligence in the performance of his duties, and can be personally liable if he does not. The Georgia statute requires that:

“Directors and officers shall discharge the duties of their respective positions in good faith and with that degree of diligence, care and skill which ordinarily prudent men would exercise under similar circumstances in like positions.”

Many court decisions in Georgia and elsewhere hold that the director occupies the position of a “trustee” or “fiduciary” as respects the corporation and its stockholders and must comport himself accordingly. A director cannot absolve himself of this duty by inattention, lack of knowledge of details or absorption in his regular business or profession. He has the positive duty to attend meetings whenever possible, keep himself well informed and be diligent and careful about the corporation's affairs.

Penalty of Negligence

An unfortunate example of what not to do is contained in a recent case decided by the Georgia Court of Appeals involving a Georgia physician. In this case a corporation was alleged to have violated the Georgia law regulating the issuance of stock. Under such circumstances, a person who has purchased unregistered stock may sue the corporation and the directors for the return of his money. Since it appeared that recovery from the corporation was unlikely, a disgruntled stockholder sued the directors of the corporation personally, demanding his money back.

One of the defendant directors was a physician. This physician did not par-

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

ticipate in day to day operations of the corporation, did not attend any directors meetings at which the improper stock sale was voted upon, and did not know the sale had been approved. In essence, his defense was a total absence of participation in any of the transactions on which the lawsuit was based.

The court denied the physician's defense and held that he could be personally liable. The decision was based upon the Georgia Securities Act which imposes liability upon persons who "participate" or "aid" in the sale of unregistered securities. The court said that to "participate" or "aid" in unlawful stock sales does not require overt or direct activity; a director may be legally liable because he failed in his duty of attention, care and diligence. The decision explains that "do-nothing" or "window-dressing" directors can thus be responsible for actions they did not specifically approve or participate in. According to the court, Directors "owe a duty to exercise reasonable care and prudence, and not be mere ornaments or figureheads."

Sample of Dangers

We have here a large body of corporate law, and it is impossible to detail all dangers. However, some of these are:

1. Issuance and sale of securities (stocks, bonds, notes, land syndication shares, etc.). There are quite restrictive federal and state statutes and regulations on this subject which must be complied with to avoid liability. The securities area would also include such matters as (i) requirements of reporting certain transactions to appropriate authorities, (ii) use of inside information, tips and other data unknown to the general public, (iii) restrictions on re-sale of securities, even when properly registered, by directors and other persons in control of the corporation, and (iv) giving misleading information, or withholding information, in registration applications, and reports to stockholders and the general public.
2. Corporate activities beyond the powers granted in its charter or articles of incorporation.
3. Declaration of dividends or redemption of stock in violation of statutory restrictions.
4. Any sort of self-dealing or conflict of interest situations.
5. Beginning business operations before the corporation is legally and formally incorporated and organized.

It should be pointed out that Georgia law does permit the corporation, in certain situations, to indemnify its directors against personal liability for their actions and to purchase insurance to cover this liability. Physicians who are directors might have their corporate attorneys investigate these possibilities. Further, the Georgia law also states that, in discharging their duties, directors, when acting in good faith, may rely upon financial information represented to them to be correct by certain officers of the corporation or as stated in written reports by independent public accountants.

As said above, this is a large and complex area which this brief note cannot possibly cover. The purpose of this article is to alert physicians to the possible danger so that they may have their own lawyers advise them as to their particular situations and circumstances. In any event, at the very least, a physician who is asked to serve on a board of directors should thoroughly investigate and be familiar with the corporation and the other people involved; attend meetings, keep up with the corporation's affairs, be alert and ask questions; require that regular meetings be held and that regular reports, financial and otherwise, be available; and insist on legal advice where it seems appropriate.

*Eleventh Floor
C & S National Bank Building 30303*



THE ASSOCIATION

NEW MEMBERS

Alabanza, Florentino Active—Cherokee-Pickens —OBG	Canton Medical Center Canton, Georgia 30114
Armstrong, Nathaniel E. Active—Glynn—Su	P.O. Box 1258 Brunswick, Georgia 31520
Bunyasaranand, Pricha Active—Spalding—D	610 S. 8th St. Griffin, Georgia 30223
Clark, Roland B. Active—Glynn—Oph	2705 Wildwood Drive Brunswick, Georgia 31520
Dunaway, Marshall C. Active—Thomas Area—I	900 Gordon Avenue Thomasville, Georgia 31792
Hardwick, B. Randol Active—S. Georgia—N	305 University Drive Valdosta, Georgia 31601
Levy, Louis I. Active—Muscogee—Pd	1968 North Avenue Columbus, Georgia 31901
Leyva, Jose Santos Active—Clayton-Fayette— —OBG	217 Arrowhead Blvd. Jonesboro, Georgia 30236
Maxwell, Robert Blair Active—Thomas Area—Pd	509 Gordon Avenue Thomasville, Georgia 31792
Phillips, James E. Active—Bibb—Path	777 Hemlock Street Macon, Georgia 31201
Pierce, Mart T. Active—Glynn—FP	P.O. Box 1003 Brunswick, Georgia 31520
Shih, Chen-Wen Active—Wayne—OBG	P.O. Box 406 Hinesville, Georgia 31313

PERSONALS

First District

K. Allen Harper, Savannah plastic surgeon, has been certified by the American Board of Plastic Surgery. Dr. Harper has received training at Baylor College of Medicine in Houston, Texas and Duke University.

Second District

Dr. and Mrs. J. Daniel Bateman of Albany represented GaMPAC at a June 22 dinner given by the National Press Club in Washington, D.C. honoring "Georgia Night." The Batemans were accompanied by State Senator and Mrs. Al Holloway of Albany. Dr. Bateman is chairman of GaMPAC and Mrs. Bateman is co-chairman for women's activities. During the trip, Dr. Bateman was able to contact several members of Georgia's congressional delegation including Senator Sam Nunn.

Third District

Wallace Lucas of Cochran announces that **Charles P. Brooks**, formerly of Conyers, is now associated with him in the practice of medicine. Dr. Brooks received his M.D. degree from Tulane University in New Orleans.

J. C. Serrato of Columbus has been reappointed to a four year term on the State Medical Education Board for which he is vice chairman.

Fourth District

Thomas B. Janter of Chamblee and **Stanley M. Tenenbaum** of Sandy Springs are among 258 physicians recently elected to Fellowship in the American Academy of Pediatrics.

Fifth District

Four faculty members of the Emory University School of Medicine Department of Surgery have been promoted to full professor: **J. Richard Amerson**, **Garland D. Perdue**, **H. Harlan Stone** and **Panagiotis N. Symbas**.

Ivan A. Backerman has been elected chief of staff at South Fulton Hospital.

William E. Huger, Jr., has been re-elected treasurer of the Southeastern Society of Plastic and Reconstructive Surgeons.

Alexander S. McKinney is the author of "Neurologic Findings in Retroperitoneal Mass Lesions," published in the August issue of the *Southern Medical Journal*.

Elected chief of staff at Georgia Baptist Hospital is **Edwin C. Evans** of Atlanta.

Louis Felder is serving the Georgia Society of Internal Medicine as president-elect and current secretary-treasurer.

W. Douglas Skelton has been named deputy superintendent in charge of adult psychiatry at Georgia Mental Health Institute in Atlanta.

Asa G. Yancey, medical director of the Fulton-DeKalb Hospital Authority, joins 59 other new members of the Institute of Medicine, whose election means they will devote a significant proportion of their time working on institute panels and committees engaged in health policy studies.

Sixth District

College Park physician **A. R. Evans, Jr.**, has been elected vice president of the University of Tennessee General Alumni Association.

Calvin Jackson of Manchester has been appointed a member of the State Medical Education Board for another four year term by executive order of Governor Jimmy Carter. Dr. Jackson has been nominated chairman of the Board, succeeding himself.

Seventh District

William Henry Lucas, former chief of medical staff at Floyd Hospital in Rome, was presented a plaque of appreciation at the July meeting of the Floyd Hospital Authority.

Robert D. Walter, Calhoun, received the "Citizen of the Month" award of his city's Kiwanis Club in July where he was cited for his devotion to the medical profession and to his community.

Eighth District

William George Dunbar is bringing his practice of medicine and general surgery to St. Marys after practicing in Wrens since 1969. Dr. Dunbar is a 1956 graduate of the Medical College of Georgia.

Carter Meadows is moving his practice from Jesup to Emanuel County.

Tenth District

After serving 35 years as professor and a chairman of

anesthesiology at the Medical College of Georgia, **Perry Volpitto** has retired and been named professor emeritus by the Regents of the University System of Georgia.

George H. Nelson of the Medical College of Georgia in Augusta is the author of "Determination of Amniotic Fluid Total Phospholipid Phosphorus as a Test of Fetal Lung Maturity" published in the April issue of the *American Journal of Obstetrics and Gynecology*.

Audrey K. Brown of the Medical College of Georgia addressed the American Academy of Pediatrics Special Conference in Burlington, Wisc. on the "Susceptibility of the Fetus and Child to the Effects of Chemical Pollutants."

The following staff members of the Medical College of Georgia have been awarded grants recently: **Curtis H. Carter**, dean, School of Medicine, from the National Institute of Health; **Paul D. Webster, III**, from the National Institute of Arthritis; **George H. Nelson**, from the Dept. of Health Education and Welfare; **E. James McCranie**, from the National Institute of Mental Health.

HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

July 22, 1973

Morehouse Medical/Dental Education Feasibility Study: Endorsed the study of the feasibility of a new medical/dental educational program at Morehouse College.

Headquarters Office: Due to increasing space requirements, reactivated Ad Hoc Committee to Study Building and Land and to examine options available to MAG concerning present building and the obtaining of a new Headquarters office site.

Special Session, House of Delegates: Approved recommending to Council that Special Session be called for December 15 to review the EMCRO project and make determination regarding its becoming operational.

PSRO: Received report on PSRO situation in Washington and in Georgia as well as AMA activities regarding PSRO. Reaffirmed continued support and planning for concept of single state-wide PSRO in Georgia.

Georgia Medical Care Foundation: Report received on signing of new contract between Foundation and Medicaid Program. Also learned of new on-site nursing home review activity as well as plans for state-wide hospital CHECK program.

MAG Support for MECO: Approved support of Medical Education and Community orientation projects which may be developed by SAMA Chapters at MCG and Emory.

Appointments: Committee on Woman's Auxiliary—George I. Harrison, M.D., Marietta; Committee on Education—Nicholas E. Davies, M.D., Atlanta (Chairman).

EMCRO Committee—Ollie M. McGahee, Jr., M.D., Jesup (chairman); W. Upton Clary, M.D., Savannah; John I. Dickenson, M.D., Rome; John R. McCain, M.D., Atlanta; Charles E. Todd, M.D., Atlanta; Lamar S. McGinnis, M.D., Decatur; Donald J. McKenzie, M.D., Thomasville; D. R. Mahan, Jr., M.D., Dalton; Jack A. Raines, M.D., Columbus; Robert B. Copeland,

M.D., LaGrange; Joseph M. Turner, M.D., Tifton; R. H. Vaughan, M.D., Columbus; Thomas E. Whitesides, Jr., M.D., Atlanta; Joseph S. Wilson, M.D., Atlanta; Ellis D. Keener, M.D., DeKalb.

PSRO Study Committee—Charles G. Hollis, M.D., Albany (chairman); J. Dan Bateman, M.D., Albany; James J. Oosterhoudt, M.D., Dalton; F. W. Dowda, M.D., Atlanta; John P. Heard, M.D., Decatur; R. D. Walter, M.D., Calhoun; Charles W. McDowell, M.D., Decatur; L. C. Buchanan, M.D., Decatur; J. K. Quattlebaum, Jr., M.D., Savannah; A. J. Kravtin, M.D., Columbus; Ronald F. Galloway, M.D., Augusta; Beverly W. Forrester, M.D., Macon; Joseph M. Almand, Jr., M.D., LaGrange; James A. Kaufmann, M.D., Atlanta; W. Dan Jordan, M.D., Atlanta; Louis H. Felder, M.D., Atlanta.

Committee to Study MAG Functions, Structure, and Organization—David A. Wells, M.D., Dalton (chairman); Ronald A. Galloway, M.D., Augusta; Joseph C. Stubbs, M.D., Valdosta; Hurley D. Jones, Jr., M.D., Brunswick; Robert E. Wells, M.D., Atlanta; C. Dan Cabaniss, M.D., Columbus; O. Wytch Stubbs, Jr., M.D., Chamblee.

Committee on Membership—Joseph M. Almand, Jr., M.D., LaGrange (chairman); Jack S. Menendez, M.D., Macon; Edwin A. Mayo, M.D., Brunswick; Paul L. Bradley, M.D., Dalton; D. L. Brawner, M.D., Savannah; Joseph L. Girardeau, M.D., Atlanta.

Committee on Access to Health Care—M. C. Adair, M.D., Washington (chairman); Louis H. Felder, M.D., Atlanta; W. E. Coleman, M.D., Hawkinsville; J. Mack Sutton, Jr., M.D., Albany; Dwight J. Brown, M.D., Brunswick; Harvey M. Newman, M.D., Gainesville; Lawrence L. Freeman, M.D., Chamblee; J. Gary Palmer, Jr., M.D., Marietta.

Site of next meeting: 10 a.m., August 26, 1973, MAG Headquarters, Atlanta, Ga.

THE MONTH IN WASHINGTON

In an effort to reach some hard conclusions in the fuzzy area of the impact of various kinds of health insurance on health care, the federal government is starting a \$30 million experiment.

Some of the questions that researchers hope to answer are:

—Would erasure of all financial barriers cause a surge of demand?

—Do deductibles and co-insurance exert a brake on frivolous or excessive use of physicians and hospitals?

—Do families alter their patterns of physician-hospital utilization depending upon their type of insurance? How is their health affected?

The study, handled by the Office of Economic Opportunity (OEO) in conjunction with the Health, Education, and Welfare Department, will cover 2,000 families containing about 7,500 people. It will last up to five years. About 100 families in Dayton, Ohio, will be enlisted shortly. Four other cities eventually will take part. The participants' identities are confidential.

The HEW Department is slated to take over the project next year. Noting the proposals before Congress for national health insurance (NHI) programs, the OEO says, "The federal government will inevitably play a major role in determining the way in which the nation's health insurance plans operate. Unfortunately, current knowledge of health economics is not sufficient to predict the effects of public policies related to health insurance."

Those in the experiment will have to give up existing health insurance policies. New ones will be provided free as far as policy cost is concerned. The coverage will take three basic forms:

(1) No deductible; no co-insurance. Basically unlimited free medical care.

(2) \$100 yearly per-person deductible, no co-insurance.

(3) No deductible, 20 per cent co-insurance.

There will be variations on these plans. But all will have a catastrophic provision above a certain amount of out-of-pocket costs determined by some fraction of the yearly family income.

Officials concede that Congress may enact a NHI bill before much meaningful data is accumulated from the experiment. Nevertheless, they say, the information will be valuable and could lead to adjustments in any existing national program.

Benefits will vary in the experimental plans. One will cover all visits to physicians' offices while the patients share hospital costs. Psychiatric care will be limited to 50 outpatient visits annually. Dental care will be confined to children and exclude orthodontic work.

Families of all income levels will be included, up to \$25,000 a year. All participants will be interviewed in depth; about one-third will receive physical examinations.

The experiment is being conducted under a grant to the Rand Corporation, Santa Monica, California; a subcontract for operational work is held by Mathematica, Inc., of Princeton, N. J.

Exploding Myths

No one will be surprised if some commonly-held notions aren't exploded when the project is finished. A little-publicized HEW study, for example, indicates that

average costs per medical visit are much cheaper with the private practitioner than at a neighborhood health center or a prepaid group practice. The estimated private costs ranged from \$6.58 to \$10.63 by specialties. In contrast the cost per visit at 18 well-established neighborhood health centers was \$21.16. The pre-paid group rate was figured at more than \$18.

The report, prepared by the office of the Assistant HEW Secretary for Planning and Evaluation, said that strict comparisons among the three modes of delivery are difficult and subject to interpretation. Yet "the order of magnitude difference was far greater than had been anticipated."

Taking into account all variables, the report said "When related to the estimated private practice average cost per visit the (neighborhood) center physician encounter cost appears to be extreme in nature."

On the surface, though the study group took pains not to put it so bluntly, the report indicated that larger delivery systems might not be as efficient and economical as the solo practitioner.

The report concluded:

"Like any analysis, this study raised questions which others must examine and answer. Unfortunately, the luxury of time to answer these questions is not available. As we move through a period of rapid social and health policy change the need for these answers becomes almost immediate."

National Insurance

The Administration hopes to come up with a new national health insurance plan by late September. HEW Secretary Caspar Weinberger said consideration centers around two approaches:

—A combination of employer-mandated coverage plus federally financed catastrophic protection, or

—A national plan modeled after the Federal Employees Health Benefits Program.

The two options listed by Weinberger aren't mutually exclusive. How the Federal Employees Program (FEP) could be translated into a national plan was not explained. Government workers under FEP can choose among high and low indemnity or service plans of private insurers and the Blues with the federal government paying a set share. Prepaid group practice is another choice. Presumably, a national plan would have the private employers financing the share paid by Uncle Sam for U. S. workers.

The first mentioned plan sounds like the previous Administration proposal with the exception of a strong catastrophic plank plus universal coverage, not provided before.

Whatever scheme is picked, Weinberger said, it will include a partnership concept involving private insurance and public agencies that will (1) assure that all have access to basic comprehensive coverage regardless of lack of sufficient income; (2) will make judicious use of co-insurance and deductibles; and (3) will contain features "to halt or at least sharply reduce medical cost inflation."

Roll Back Requested

Leonard Woodcock, President of the United Auto Workers, has called upon the Administration to roll

back health insurance premiums under Phase IV of the Economic Stabilization Program. The labor leader who is chairman of the Committee for National Health Insurance (CNHI) said the commercial health insurance industry "has reaped a huge windfall" under Phase II and Phase III regulations.

Woodcock said the six largest health insurance companies had "increased their net gain from group health operations to \$140.1 million last year from \$31.9 million in 1971. . . . A 350 per cent increase."

He appeared at a Washington news conference with Luci Johnson Nugent, daughter of the late President Lyndon Johnson, and leading members of CNHI. Mrs. Nugent announced her support of the Kennedy-Griffiths health security bill backed by organized labor and the CNHI.

A spokesman for the Health Insurance Institute, representing the insurance industry, denied Woodcock's charges and said the industry experienced a profit of only 1.5 per cent on premiums during 1972 based on an analysis of 20 companies.

"Because they were not windfall profits on a general, across-the-board basis, there would seem to be little need to roll back health insurance," the spokesman said.

Commissioner Named

Alexander MacKay Schmidt, M.D., has been named Commissioner of the Food and Drug Administration.

Dr. Schmidt, 43, succeeds Charles C. Edwards, M.D., who is now Assistant Secretary for Health of HEW.

From 1970 until earlier this year, Dr. Schmidt was dean and professor of medicine at the Abraham Lincoln School of Medicine, University of Illinois College of Medicine.

Dr. Schmidt previously served in HEW as chief of the continuing education and training branch, Regional Medical Program, from August 1967 until December 1968. From there he went to the University of Illinois College of Medicine as executive associate dean and associate professor of medicine, before being named dean and professor of medicine.

Dr. Schmidt received the Bachelor of Science degree from Northwestern University in 1951 and his M.D. degree from the University of Utah College of Medicine in 1955. From 1960 to 1967 he held various academic positions at the University of Utah College of Medicine.

Brookings Report

The prestigious Brookings Institution has come out with another provocative overview of U. S. Government policies that declares socialism in the European vein "has negligible support in the United States."

"... there appears to be little support for direct provision by the federal government of public services, especially such human services as education, health care, and law enforcement," the report says.

The Brookings report "Setting National Priorities—the 1974 Budget" last year proved a landmark "think piece" that helped set the tone for the Nixon Administration's domestic policy programs in 1974. That report urged "social experiments" by the government before embarking on major new national programs. Many believe the private foundation's report was a major factor in the Administration's decision to slash the scope of its Health Maintenance Organization (HMO) program

to a strictly experimental project.

In the latest report's discussion of national health insurance (NHI), the concept of relating benefits to income is endorsed. This is a prime feature of the American Medical Association's Mediredit proposal.

The Brookings report said:

"The type of proposal that seems best adapted to meeting all three criteria of equity, protection and efficiency is a national health insurance plan with income-related benefits. Under such a plan, both deductibles and co-insurance would be related to income so that people would be protected against expenses that were high relative to their income. To prevent undue financial burdens, a ceiling related to income could be placed on the out-of-pocket expenses a family would have to pay. One advantage of such an approach is that a single plan would serve the dual purpose of protecting the poor against normal expenses and protecting higher income people against heavy expenses; hence no stigma would be attached to receiving benefits under the plan."

Keogh Plan Liberalized

The Senate Finance committee has voted a substantial liberalization of the Keogh plan for self-employed people, including physicians, but also added restrictions on retirement savings by professional corporations.

Committee Chairman Russell Long (D., La.) said the season for the restrictions was the fact that in some cases professional men who had incorporated and who had high incomes could set aside on a deferred taxation basis as much as \$32,500 yearly while the self-employed were limited to a maximum of \$2,500.

Under the new Keogh plan limits set by the Committee, which are expected to win Senate approval, physicians, lawyers and dentists and other self-employed are allowed a deductible contribution to a retirement plan of up to 15 per cent of earned income with a maximum of \$7,500 annually. There would be a \$100,000 limit on earned income that can be taken into account. (Present law limits retirement set-aside subject to tax deduction to 10 per cent of earned income but not more than \$2,500).

According to the Committee, the \$100,000 limit means that "higher income self-employed, desiring to achieve the \$7,500 maximum contribution for themselves, will find it necessary to contribute on behalf of their employees at a 7.5 per cent or greater rate."

The same self-employed plan limitations were imposed on retirement contributions on behalf of certain owner-managers of corporations. These owner-managers subject to the limitations would be those having more than a two per cent ownership interest in the stock of a corporation but only of all such persons in a particular corporation in the aggregate have more than a 25 per cent interest in the contributions or benefits of the pension plan.

An increasing number of physicians in recent years have formed professional corporations in order, among other reasons, to be able to invest more in retirement savings plans with tax deferrals than possible under the self-employed Keogh plan.

The new plan, believed to have the endorsement of the Administration, stands a good chance of Congressional approval.

Reimbursing Home Services

Congress has been asked to approve practical, rea-

listic programs for reimbursing effective home health care agencies and programs.

The American Medical Association told the Senate Aging Subcommittee the range of home services covered by government programs needs reexamination.

"Physicians . . . who want the best possible care for their patients must be allowed to order and to provide preventive, supportive, and rehabilitative services at home as they presently do at other sites," testified Charles Weller, M.D., a member of the AMA's community health care.

Dr. Weller noted that home care agencies have been protesting the Social Security Administration's policies on the home health provisions of Medicare in as much as less than one per cent of Medicare dollars go for this type of health care.

As evidence of the AMA's strong support of the concept, Dr. Weller pointed to the important home health services component in the AMA's Medigredit national health proposal.

"Effective programs of home care services can reduce costly inpatient stays and achieve significant savings," Dr. Weller said.

"In summary, the AMA actively supports the development and expansion of sound home care programs. We will continue to urge that they be covered under both private and public programs. We believe they can aid selected patients, reduce costs, reduce institutionalization, and provide valuable assistance to physicians whose patients participate in them. More education is needed about the benefits of home care programs, and physicians will continue their efforts in this field."

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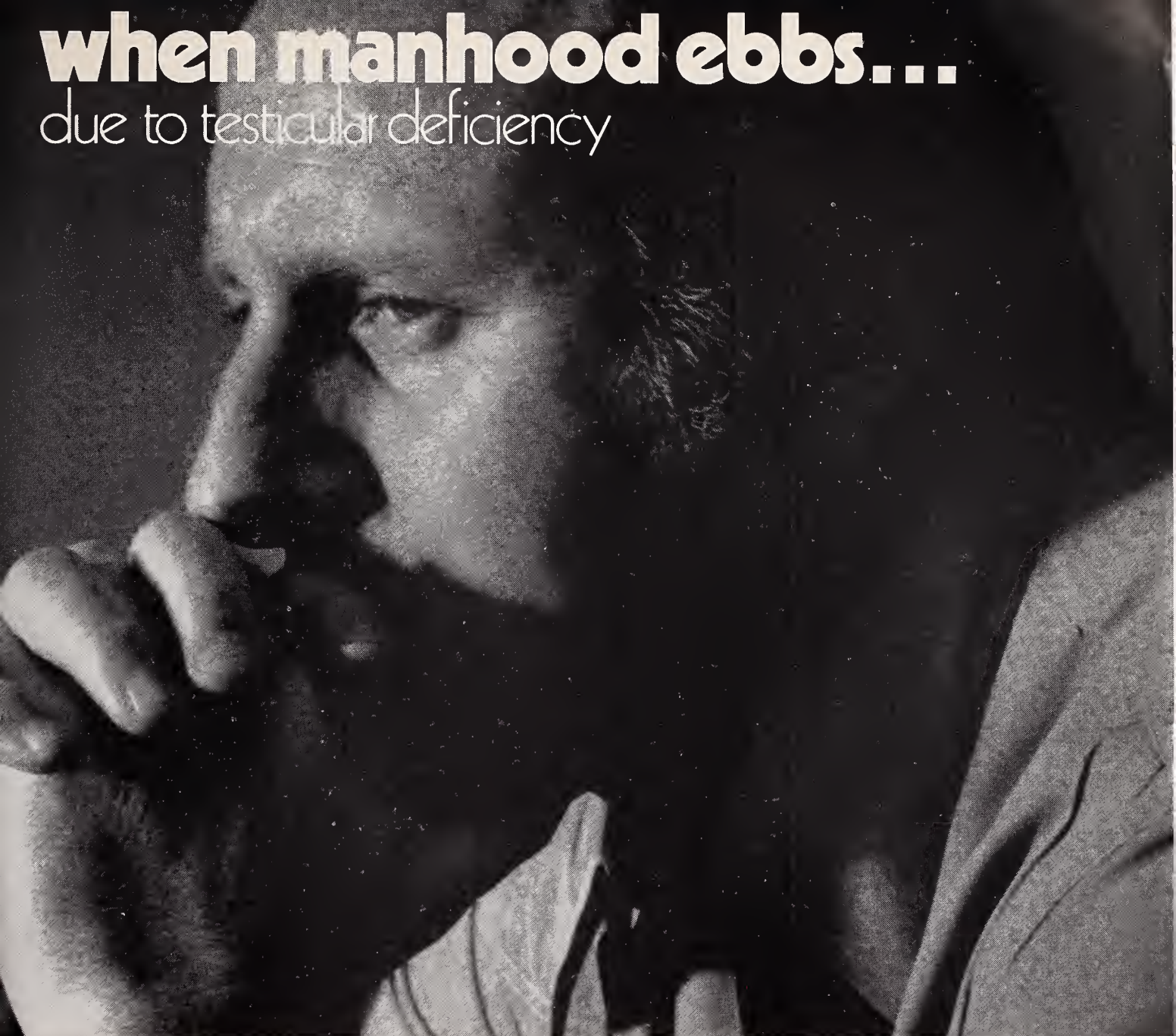
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Cover

The inviting telephone introduces MAG members to a new service available in October—a direct, toll-free line to the Atlanta Headquarters. For details, see Page 349. Cover by Atlanta artist Bob Hamill.

We are faced with a crucial time when a general feeling of discontent prevades all elements of our health economy—doctors, government and patients.

Is There a Crisis in American Medicine?

A. J. VOGL, *Oradell, New Jersey**

AS AN EDITOR OF *Medical Economics* for eight years, I've been on a team that occupies a unique listening post. In the course of producing articles for the magazine, we are in daily contact with the providers and the consumers of health care, and everybody in between. Our understanding of what's happening today is further deepened through the articles doctors themselves submit to *Medical Economics*, through their letters to the magazine, and through their responses to advance drafts of articles that we customarily send out.

Against this background of our magazine's continuing dialogue with the health sector, I'd like to tackle the question: "Is there a crisis in American medicine?"

Crisis Defined

For starters, let's be clear about what we mean by *crisis*. The first definition in my dictionary says that *crisis* means "the turning point for better or worse in an acute disease or fever." Since we're discussing American medicine, the metaphor of illness seems particularly appropriate. But who is sick?—the doctor or the patient, the system or the people served by it? It's difficult to totally separate supply from demand because we are all part of both. Certainly, poor or absent doctoring or a worn-out or diseased system can help make people sick—both literally and figuratively. Have we reached that kind of turning point? Has American medicine so deteriorated, or are new demands on it so compelling, that some-

thing drastic must be done if the health of the American people is to be assured?

I think the answer to that specific question is "no." Our national health is not in new jeopardy. Still, there are crises for some of the people some of the time—for patients and their families during catastrophic illness, for example. And there are crises for other people much more of the time—the poor and others without access to decent health care. For most of us, however, there are instances of frustration and disappointment, but nothing new, and nothing that can be labeled *crisis* according to the turning-point definition.

But my dictionary also offers a second definition of *crisis*: an unstable or crucial time or state of affairs." Does this description fit American medicine at this time?

I suggest it may, in a number of ways. Although the most outspoken health critics do their best to paint our state of affairs in black-and-white polarities, the real world is not so simple. What we have today is *not* a standoff battle between the various elements of our health economy. Rather, we have a general feeling of discontent that pervades all elements—doctors, government, and patients. While each element has particular reasons for its discontent, the end product strikes a common chord—that our state of affairs is not really bad so much as it's not as good as it ought to be.

Doctors' Discontent

I can see one manifestation of this discontent in doctors' feelings toward the AMA. Many liberal phy-

* Executive Editor of *Medical Economics*. Mr. Vogl delivered this speech at the 119th Annual Session of the Medical Association of Georgia, May 10-13, 1973 in Augusta.

sicians feel that the AMA is obstructionist and reactionary. Some conservative doctors are convinced it is passive and pink. Still others feel that the organization is passé and out of touch, and so have nothing to do with it. Some of these doctors simply disassociate themselves from organized medicine, while other look to physicians' unions as a new hope for bringing it all together.

Why all these factions? Is it something new—that doctors' thinking now reflects as wide a spectrum of thinking as the American public's? Or was the public mistaken in ever believing that American physicians expressed monolithic or party-line thinking?

I think there is some truth in both these views. But a much more significant point, it seems to me, is that today there is no one issue that can weld doctors together in a united front.

What about government interference in the practice of medicine? you say. What about PSROs? What about National Health Insurance—the most encompassing threat of all?

I certainly don't think that most physicians like these developments or would support them wholeheartedly. But I also don't believe that any of them pose a do-or-die issue, one on which doctors will join together and rise or fall together.

Consider, for instance, government or third-party interference in the private practice of medicine. No doubt some doctors have been sufficiently discouraged by this trend to leave private practice for some sort of salaried position. Still others may have been so put off by it that they've left medicine entirely—into early retirement (if they could afford it), or into a different field altogether. There are also a few who write letters to their Congressmen or articles for *Medical Economics*, and another few who make speeches before their county or state societies or before the AMA's House of Delegates.

But what do *most* doctors do? They may grumble or shout or curse their fate, but eventually all of them buckle down and do their job.

There may be small victories along the way—such as when doctors recently forced the Aetna Insurance Company to reconsider its move to arbitrarily set fees and then support its policy holders in court if the doctor made a legal case of it. But overall, as you know, most doctors have accepted the fact that third parties are here to stay. Instead of fighting them, physicians are actively searching for new ways to meet the paperwork demands they make.

What about PSROs? Here, too, is a development that concerns many doctors who fear a "Big Brother" looking over their shoulder as they practice. But

PSROs are not so revolutionary-sounding as they might have been several years ago. Through utilization review in hospitals, through peer review, through third-party review of their fees, doctors have become *conditioned* to the idea of review; to the idea that the review mechanism may raise standards of practice; to the idea of accountability—that the bill-payers have a right to know what they're paying for. Furthermore, even if doctors haven't been completely conditioned to the idea of review, they've become sophisticated enough to realize that opposing review mechanisms would hardly enhance their reputation with the public.

National Health Insurance

Lastly, let's talk briefly about national health insurance. Surely this is the key issue for physicians, one that dwarfs all others. I agree that it is a key issue to understanding the nature of the crisis that affects American medicine today, but I do not believe it is the kind of key issue that will drive doctors to the barricades. Let me explain.

If ever a problem and solution were linked together by the media and politicians, then it was *American health crisis* (the problem) and *National Health Insurance* (the solution). Just as Marcus Welby became for millions of persons the ideal vehicle to solve medical problems, so national health insurance became the ideal vehicle to resolve the sickness of our health care system—or non-system, as it was fashionable to say only last year.

The only question seemed to be *which* national health insurance bill would be enacted? Would it be Nixon's, or the AMA's, or Kennedy's, or somebody else's. But where are we today? What happened to all the excitement, the imminence of revolutionary things to come?

For all practical purposes, these bills are in limbo now. The most promising of passage is also one of the most modest—Senator Long's bill to insure the expenses of catastrophic illness.

Is this a victory for physicians? It may be considered so, but I don't think their voice was decisive. If I correctly read physicians' feelings over this issue, then I believe that most of them feel that the battle over national health insurance has already been lost; that it's not a matter of whether or not national health insurance, but, rather, what kind and how it will be put into effect. This admission of inevitability was reflected in the role doctors and the medical establishment played in the national health insurance debate. It was nothing at all like the pitched battle over Medicare in 1965, when the AMA pulled out all the stops.

And yet, despite this feeling of inevitability, a national health insurance bill still remains a prospect rather than a reality. Why? Remember that

"Whether or not there is a crisis, many people believe there is a crisis, and that amounts to the same thing in important respects." . . . A. J. Vogl



second definition of *crisis* I cited earlier: "an unstable time or state of affairs." I think national health insurance is hooked into that feeling of instability, of doubt and skepticism and discontent.

Government's Concern for Dollars

That feeling is certainly reflected by Government, which has been shaken by the costs of Medicare and Medicaid. The cost prospect of truly comprehensive legislation is enough to make even a liberal Congress hesitate. It is certainly aware of the public's feeling about inflation and higher taxes. According to a recent newspaper report, the Harris Poll found 59 per cent of the people surveyed in agreement with the statement that "President Nixon is right in saying that inflation cannot be controlled unless Federal spending is cut to the bone." To talk about cutting Federal spending and embarking on comprehensive national health insurance is virtually a contradiction in terms.

But it is not just the dollars involved. I think people in Government are beginning to realize that better health care is not simply a matter of money; that past a certain point, there is a diminishing return in health for the dollars invested. At that point somebody usually speaks of the necessity for institutional reform and radically changing the health care delivery system. But here, too, on the part of the Government, I detect a "go slow" pluralistic approach that favors broad-spectrum experimentation rather than lockstep planning. The HMO concept is by no means discredited or dead, but I don't hear politicians or planners talk anymore about having health care in the U.S. entirely delivered by a network of HMOs. Undoubtedly there will be more pre-payment approaches in the years to come, but it will be many years before fee-for-service will be

regarded as a curiosity from another age. Big groups of doctors, heretofore regarded as the logical successor to "cottage industry medicine," are also being critically examined. There was always a notion that big groups practiced better medicine, even if there wasn't a cost saving. That may well be, but it still remains to be proved, as was pointed out in a recent *Medical Economics* cover story called "The Economic Case Against Big Groups."

Doctors, for that matter, are themselves challenging hallowed traditions of medical economics, raising questions that formerly might very well have been considered beyond the bounds of legitimate discussion. Again, let me give you several examples from recent issues of *Medical Economics*, all of them articles bylined by doctors:

"How much should a surgeon—or any other doctor—earn," in which the author argues that doctors' incomes should be within hailing distance of each other. He concludes: "As long as one doctor can earn \$200,000 a year and another only \$18,000, with only the whims of the marketplace to account for the difference, the public will have little interest in our Socratic attempts to justify a reasonable place for ourselves in the economic structure of society."

"The case for a national fee schedule," in which the author asks why the cost of medical care should vary so much regionally when the price of other goods and services do not. "We're paid for a service rendered, not for an accident of location. . . . The majority of the working people who keep America going—store clerks, bus drivers, gas station operators—are earning pretty much the same all over, with perhaps a variation of 10 or 15 per cent. Yet you see doctors charging twice as much in one area as in another."

We even published an article recently titled, "Face It: We Can Learn From Chiropractors," in which the doctor-byliner urged colleagues not to reject manipulative therapy out of hand, but to adapt it—"knowledgeably and selectively"—for his own uses. Since chiropractors refuse to go away despite the best efforts of the AMA, his suggestion has much to commend it.

Patients' Revolt Slows

So far, I've discussed this feeling of instability and discontent in terms of the Government and physicians. What about the public, the consumers of medical services? After all, it was the so-called "patients' revolt" that was going to compel the system to change and doctors with it. That was only two or three years back, although it seems much longer ago. Since then, the momentum for revolt or even reform has slowed considerably. For one thing, the so-called health coalition of that time—between the poor, the middle-class, big business and organized

labor—is no longer the same, cohesive force. Second, other issues—inflation, taxes, crime—are today pre-eminent over health. During our last election year, I think the relative importance of the health issue was brought home to politicians. It's not that health was a false issue, but unless a person is sick or somebody in his family is, the issue of health doesn't have the immediacy of the price of meat. Then, too, I think there is a growing public awareness that there is no "free ride." Whether health insurance is paid for out of general tax revenues or is employer based, people are aware that ultimately they will have to pay for it.

I also believe public opinion reflects a philosophic uneasiness about reorganizing the health care system and instituting cradle-to-grave health insurance.

We are living in a time where more and more people believe that big is not necessarily better, and that certainly includes big government. Decentralization and individual initiative are the new imperatives.

New life styles are being tested. The work ethic is being seriously questioned. The computer is no longer our great white hope. People are trying to break out of the assembly-line of their jobs and of their personal lives. They are hardly in a mood to seek out assembly-line medicine produced under the auspices of big government. While doctors worry that the government seeks to cast them into the role of technicians, they should also realize that the public has had its fill of dehumanizing technology masquerading as a so-called technological miracle.

The public's philosophic uneasiness also expresses itself in disbelief—of the economy (consider the current state of the stock market); of politicians and government (Watergate stands as a memorial to remaining illusions); of the mass media (it's gradually dawning on people that television news does not report on events, but on pseudo-events created for our nightly news programs); of advertising (we are past the point where even Nader's Raiders can surprise or outrage us).

If disbelief is an expression of the temper of our times, a groundswell for national health insurance is improbable. Indeed, when was the last time you saw a true sustained groundswell for anything? Political commentators like to think the phenomenon exists, but most groundswells only have the staying power of fads.

Not that the public feels our health system is perfect. Far from it. It's just that people have stopped believing that revolutionary change will automatically make things better. Better, they say, to patch up and make do with what we have.

It is for these reasons that I believe the public resists national health insurance at this time, not because they believe what the medical establishment tells them. No, I'm afraid that the public's disbelief also extends to physicians—and by that I don't mean what a person feels about his personal physician, but what people feel about doctors as a class.

Let me give you an example: With respect to national health insurance and other crucial issues, organized medicine has always maintained that its positions were taken in the name of preserving the doctor-patient relationship. I think this argument holds less weight with the public today, and it will hold even less in the future. The clincher may very well be doctors' unions. For physician-unionists to claim, openly or through implication, that a major purpose of their unions is to protect their patients is a strain to credibility. The same strain showed in the last several years during strikes by school teachers, who claimed they were striking for a better education for their pupils. This may indeed occur, but it is neither the primary reason for the union nor the strike. In a similar way, if the physicians union movement grows, doctors must face the fact they are going to be regarded as economic beings first, and as professional men and humanitarians second. Not to mention the fact that it will be difficult indeed, to persuade the public to relate to and sympathize with the plight of a group whose members have median incomes of \$40,000 per annum.

At the same time, I think that in the years to come the doctor and patient will legitimately identify with each other against the Government. Already we are seeing the Government renege on its Medicare promises. In an award-winning article for *Medical Economics*, "Guess who's losing those doctor vs. Medicare games," a doctor described how he and his colleagues had to fudge on diagnoses to make sure Medicare would pay for the bills their elderly patients ran up in the hospital. His local hospital, incidentally, was party to the gambit, and even circulated a list of 38 diagnoses "considered questionable by Medicare for payment purposes." The doctor's initial reaction? "But this list," he said, "seems to include almost everything old people might get that would require hospitalization."

Reports from other parts of the country tended to corroborate this doctor's experience. If benefits are extended to other sectors of the population, and the government again tries to economize, the doctor-patient alliance will very likely deepen and broaden.

Competition for Patients

Also, at the same time, I believe there will be far more competition for patients in the years to come.

For one reason, the golden age of demand for physicians and their services will draw to a close as greater numbers of doctors are turned out. Remember, most of them will choose to set up their practices in the most desirable geographic areas. Already we're seeing signs of surplus. Recently, for instance, we received a manuscript from a doctor in the far west, who described what it was like to practice in a city that was literally over-doctored because it was such an appealing place to live and practice.

Growing competition between physicians will be accompanied by an increased tendency on the part of patients to regard medicine as a service comparable to other products and services in the marketplace. Already more precise diagnostic and treatment yardsticks are being developed to define the product; and, as I said earlier, patients and their insurers are becoming hard-nosed about evaluating exactly what they're getting for their money.

Kentucky Fried Medicine

Does the doctor-patient relationship represent a real product difference to the buyer? We'll have a better bead on the answer as the market becomes more competitive. Probably the sternest test of the value of the doctor-patient relationship will occur if health care is no longer so dominated by physicians. Major franchise operators like Kentucky Fried Chicken and Holiday Inns are considering entering the healthcare marketplace. Some would just provide such outpatient services as laboratory testing, but others plan to hire doctors and set up full-scale health maintenance organizations. Will patients be put off by the kind of minimal relationship with a doctor implied by Kentucky Fried medicine?

Another heavy question is whether such fran-

chises represent "the commercial exploitation of medicine"? That's what many California doctors claimed recently when they succeeded in persuading Governor Ronald Reagan to veto a bill that would have allowed for-profit, commercial corporations to contract with doctors and establish prepaid health insurance programs in that state. I understand that afterwards, however, Reagan said he was not opposed in principle to such legislation, but rather to the way it was hustled through the legislature. In any event, I don't think this trend can be stifled by a veto.

In response to the Reagan veto, a medical student wrote a letter published in *American Medical News*: He said: "Money earned in any business, medicine being no exception, is directly related to how well customers are satisfied with the service or product offered. Let's leave the solution of health care delivery to free enterprise and, therefore, let the people decide which system they want."

To me it's particularly ironic that this letter was written by a medical student, when his counterpart a few years ago would have called for *less* free enterprise and *more* government involvement in medicine.

As much as anything, such turnabout thinking reflects the ferment and instability prevalent today. It's up to you to decide whether our current mood merits being called a crisis. But let me leave you with one thought: Whether or not there is a crisis, many people *believe* there is a crisis, and that amounts to the same thing in important respects. Unless we are willing to accept this as a point of departure, then it will be virtually impossible to change public attitudes that are not rationally in accord with the facts.

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GEORGIA REGIONAL HOSPITAL AT SAVANNAH REQUESTS HELP

The Savannah Regional Hospital has made a request for contributions for providing certain incidentals for its patients. A number of patients are without any financial means and are unable to pay for transportation home on weekends when they have a pass or are discharged. Many do not have money even for minimal incidentals which could make their life in an institution much more tolerable.

Donations should be sent to the Volunteer Services Office at P.O. Box 13607, Savannah, Georgia 31406.

and should be earmarked for the Emergency Fund. Checks should be made payable to the Georgia Regional Hospital.

This worthy cause certainly merits the consideration of our MAG members.

In cases where physicians are admitting patients to Regional Hospitals, they should suggest to the families who are in financial distress that they ask appropriate community organizations, such as Rotary Clubs, etc., for financial assistance to the hospital's fund.

The Background and Development of Peer Review

JOHN R. McCAIN, M.D., *Atlanta**

THE TIMING OF THE Seminar on Professional Standards Review Organization (PSRO) is most appropriate. Activities and responsibilities related to the development of PSRO should be under active consideration by the medical profession. It is desirable that the decisions relating to PSRO are made by individuals well informed regarding the problems and the possibilities related to such an undertaking.

The review of professional standards does not necessarily imply that the review will be done by peers. It is advantageous to consider the values of having any review of medical services conducted by peers.

The presentation today will consider the background and development of peer review. The mechanism by which peer review is conducted will be discussed briefly. It is hoped that a better understanding of peer review will enable us to be better prepared for the problems related to PSRO.

Why Peer Review?

The primary purpose of peer review is to provide excellency in the quality of medical care provided for our patients. Secondly, socioeconomic factors may be areas of consideration.

As one discusses the subject of peer review it is well to have an understanding of the definition of the terms "peer" and "review." The term "peer" ordinarily is utilized to indicate an equal. A review of medical services by peers would indicate that the individual performing the review would be an equal of the individual providing the services. The medical services provided by physicians according to peer review must be reviewed by physicians. The review cannot be done by non-medical personnel and be considered peer review.

The true peer of the physician providing the service should be a physician in the same medical specialty. As an obstetrician-gynecologist, the peer

review of my services should be conducted by an obstetrician-gynecologist. A true peer of the physician performing the services is not only a physician in the same specialty, but preferably one practicing in the same type of location, both from the standpoint of the geographic area within a state and also from the standpoint of the population density of the area.

It is my own opinion that, if a true peer as described by this definition is not available, it would be preferable to have my services reviewed by any person in the same specialty regardless of the section of the country from which he comes. I would rank this as more important than the geographic location or population density of the person performing the review. I also feel that peer review can only be provided by physicians. It is impossible for non-medical personnel to make competent judgments regarding the medical services which may have been provided in the treatment of a patient.

The term "review" literally means looking again or a relook and indicates that the reevaluation may be performed by the physician himself or by other individuals. As utilized in the term peer review, it would be assumed that those performing the reevaluation would be other than those who provided the service.

Methods of review are oftentimes classified according to the time relationship of the review to the time of the provision of the service. A retrospective review is one which is performed after the service already has been provided and perhaps after reimbursement for the service. Concurrent review occurs as the service is being provided. A prospective review is one which evaluates the proposed medical services before they have been provided. Medical services such as elective operations would be evaluated prospectively before the surgery is undertaken and perhaps before the patient is even admitted to the hospital. One of the purposes of either concurrent or prospective review is to avoid the retroactive denial of benefits for services for which reimbursement may already have been made.

* Dr. McCain is a member of the Board of Directors, Georgia Medical Care Foundation and Chairman of the MAG Peer Review Committee. This paper was presented at the Medical Association of Georgia Seminar on Professional Standards Review Organization, April 13, 1973 in Macon, Georgia.

Basic Concepts

The development of peer review has not been sudden. During recent years the importance of peer review has been recognized more fully. The mechanisms for conducting the review have become better organized. The following information is presented in an attempt to provide a better understanding for the concept of peer review.

Since the earliest days of medical care, peer review has been utilized. It is involved in the mechanism by which a physician consults with another physician regarding the treatment of a patient. It is utilized in the training of physicians in medical school, in the residency and in the postgraduate levels. Table 1 illustrates other areas in which direct and indirect review of medical treatment by peers is being and has been conducted.

Suggestions have been made from time to time that adequate review of medical care is provided by the hospital through its committees such as medical audit, tissue, and utilization review committees. Some of the reasons for the development of a peer review committee which is not limited to the medical care of a specific hospital are listed in Table 2. The current PSRO regulations indicate that for now at least the review activities will be for the medical care provided in institutions. Even for the review of institutional services, it is oftentimes desirable to have the review conducted by physicians who are uninvolved with the institution itself.

A considerable amount of medical care is provided outside of a hospital. The PSRO regulations at this time do not require the review of such care unless it is related to a nursing home or other type of institution. The responsibilities for a peer review committee involve, however, the review of ambulatory medical care. It also should involve the review of the out-of-hospital services such as laboratory and x-ray procedures and medications which are prescribed. As indicated by the seminar in session today, federal legislation is making organized review procedures by the medical profession a legal necessity.

Some Frightening Alternatives

It is frightening to consider the alternatives if physicians do not provide peer review. As indicated in Table 3, peer review should be available for all types of medical services. The PSRO review will not be required to provide evaluation except for the Medicaid-Medicare federal programs at this time. It is hoped that the medical profession will provide satisfactory peer review for the medical services reimbursed by commercial carriers as well as by governmental programs. If peer review is not provided for the services covered by commercial insurance, it can be expected that the carriers will obtain review de-

TABLE 1
REVIEW ACTIVITIES BY PEERS

Direct and indirect review of medical treatment by peers is not new.

1. Consultations.
2. Referral of patients and their records.
3. Hospital staff rounds.
4. Hospital medical staff programs.
5. Maternal and perinatal mortality review committees.
6. Tissue committee.
7. Medical audit committee.
8. Utilization review committee.

TABLE 2
REASONS FOR A PEER REVIEW COMMITTEE

In-Hospital Problems:

1. Professional objectivity is difficult if the medical staff is numerically small.
2. If the bed occupancy rate is low, effective utilization review is difficult.
3. The profit incentive of proprietary hospitals can motivate over-utilization.

Out-of-Hospital Problems:

1. Review procedures not available previously for ambulatory medical care.
2. Review needed for out-of-hospital services, including:
 - a. Laboratory procedures.
 - b. X-ray studies.
 - c. Prescription drugs.
 - d. Nursing home services.

Federal Legislation:

1. Title XIX (Medicaid) requires a review of every item of care included in a state's program.
2. PSRO will require a review of the medical services provided in institutions for Medicaid or Medicare recipients.

TABLE 3
IF NO PEER REVIEW, WHAT?

Commercial Carriers:

1. Review decisions to be made by their employed medical consultants.

Government Programs:

1. Mechanism of review to be determined by legislative action or by federal regulation.
2. Review to be conducted by medical or by non-medical personnel.

cisions from their own employed medical consultants. It is unfortunately true that the decisions made by such consultants may not be the same as would be made by the true peers of the physician rendering the service.

If physicians do not provide peer review for the federal programs, physicians can expect that a mechanism of review will be developed by legislative action or by federal regulation. Such proposals are already included in the current PSRO law. It is possible that such federal regulations may permit the

review to be conducted by medical personnel with little qualifications for the evaluation of the medical care which has been provided. It is also possible that non-medical personnel may be authorized to perform a considerable amount of the review of medical care.

If patients are to be given medical care of excellent quality, it is necessary that the evaluation of such care be made by physicians who are the peers of those who have treated the patient.

Attitudes and Problems

The reimbursement for medical services and the provision of medical services may be modified by the attitudes of those involved in the financing of the medical care. Some of the attitudes and the problems which they create are identified in Table 4. The organizations and individuals affected by the reimbursement for the services provided include the carriers whether federal or commercial, the physician himself, and the hospital or location in which the service is provided. No method of reimbursement for medical services is available which may or may not be modified by the attitudes of those involved in the provision or reimbursement of the service.

The presentation today relates primarily to the medical services provided by physicians. The other aspects of medical care such as those provided by hospitals, nursing homes, laboratories or pharmacies are discussed as they may relate to the care provided by the physicians. It is true that the direct charges by physicians for their services account for approximately only 15 per cent of the cost of medical care. The physician, however, is responsible for initiating about 85 per cent of the medical care services which are provided. It is true that the costs of nursing home care constitute one of the major aspects of adequate

TABLE 4
ATTITUDES AND PROBLEMS AFFECTING
PROPER MEDICAL CARE

- 1. Current Government health care regulations emphasize cost-containment, not quality medical care.
- 2. Government programs request peer review to determine the appropriateness of the medical service. Federal regulations control the payments for appropriate medical care.
- 3. Commercial carriers request Peer Review to determine the amount of reimbursement to be paid for medical services.
- 4. Fee-for-service medical care encourages over-utilization.
- 5. Prepaid medical care encourages under-utilization.
- 6. The Hospital Utilization Committee equation:
High bed occupancy rates = effective utilization committee action.
Low bed occupancy rates = ineffective utilization committee action.

financial support for medical services. It is urgent that adequate review mechanisms be established for these related aspects of medical care.

Committee Establishment

As a Peer Review Committee is to be established, it is well to understand the various aspects or phases of peer review. The American Society of Internal Medicine (ASIM) had described peer review as consisting of four phases as shown in Table 5.

TABLE 5
ASPECTS (OR PHASES) OF PEER REVIEW

- 1. Claims review (claims processing, clerical review).
- 2. Utilization review.
- 3. Quality review (medical audit).
- 4. Education (with discipline available if necessary).

1. *Claims Review:* The review of the claim verifies its completeness and its accuracy. No medical judgment is involved. A determination may be made as to whether or not the service provided is a "covered" service for commercial carrier's insurance policies. The claims review may be done by clerical individuals.

2. *Utilization Review:* An evaluation is made regarding the duration of hospitalization. It may also include an evaluation of the adequacy of the diagnostic tests and therapeutic procedures which have been provided. Utilization review should include underutilization as well as overutilization in its evaluation.

3. *Quality Review (Medical Audit):* The quality review evaluates the medical judgment involved in the management of the patient. The utilization review and the quality review together constitute an evaluation of the appropriateness of the medical care which has been provided.

4. *Education:* Peer review should identify areas of medical care in which additional education should be provided for the individual responsible for the medical care of the patient. The physicians will ordinarily respond very adequately if they are informed as to the medical care recommended for specific conditions. Specific educational programs may be identified for a physician or for a group of physicians. The educational aspects of peer review are potentially the most important ones for the overall improvement of the quality of care available for our patients.

Organizational Steps

If peer review is to be done in an efficient manner, it is necessary that it be organized properly. The steps in peer review may be identified as indicated in Table 6.

1. *Clerical Review (Claims Processing):* The claims are processed according to the guidelines established

TABLE 6
THE ORGANIZATIONAL STEPS IN PEER REVIEW

1. Clerical review.
2. Physician consultant.
3. Local review committee.
4. Appeal review committee.

by the third party carrier to determine whether or not and to what extent a medical service may be a covered item. Guidelines or parameters should also be established which can be programmed on a computer basis to identify claims which have been handled satisfactorily as determined by these guidelines and so do not need specific review.

Clerical review should also involve the determination of the completeness of the information provided on the claim. The apparent inaccuracies on the claim should be clarified. The individuals providing clerical review may consult with the physician provider to establish the completeness and the accuracy of the information submitted. No decisions involving medical judgment are to be made by the individuals performing clerical review. The mechanics of peer review should be established in such a fashion that at least 85 per cent of all claims which have been submitted are completed satisfactorily by this clerical review.

2. *Physician Consultant:* The claims which did not clear clerical review satisfactorily and which involve medical judgment, should be referred to the physician consultant. The physician consultant may make his evaluation of the appropriateness of the services provided on the basis of the information on the claim itself. He may request additional information from the physician provider. His disposition may involve a recommendation that the claim be paid in full, that it be denied, that the reimbursement for the services provided should be reduced. It is also possible that he request that the claim be referred to the local review committee.

It is anticipated that the physician consultant will be able to resolve satisfactorily most of the claims submitted to him and that only two to five per cent of the total claims submitted will require more review than that available from clerical review and from the physician consultant.

3. *Local Review Committee:* The local review committee has the ability to evaluate the claim and the previous clerical and physician consultant recommendations regarding it. The committee may request additional information from the physician. It may request the physician to appear in consultation with the committee. Its recommendations are essentially the same as those available to the physician consultant.

4. *Appeal Review Committee:* The appeal review

committee is expected to review one to two per cent of all the claims which have been submitted. It has the opportunity of reviewing the claim with a request also for additional information. It is at the appeal review committee that a final decision is anticipated. An appeal of the decision of this committee can be made to designated medical authorities. A review by such authorities will ordinarily involve a determination as to whether or not the earlier recommendations and decisions have been conducted fairly and properly.

Problems in Peer Review

As any committee begins its peer review activities, problems are identified almost immediately. Some of the more significant ones are designated in Table 7. These problems are discussed in more detail at this time.

1. *Selection of the physicians to conduct the review:* It is desirable that the physicians be true peers of the physicians whose services are to be reviewed. The locality from which the physician is selected for appointment to the committee should represent as closely as possible the geographic areas and population densities corresponding to those physicians whose claims are to be reviewed.

It is also desirable that the individuals on the peer review committee be appointed to represent the various medical specialties. It is desirable that the individuals for each specialty be recommended by that specific specialty organization. By this method, the specialty review will be conducted by an individual or individuals who are considered truly representative for that phase of medical practice.

2. *Identification of the Claims (or Cases) for Review:* It is desirable that an objective method be developed to determine the claims selected for review other than those undergoing clerical review. The selection of claims which involve medical judgment for peer review should not be made by clerical personnel. Criteria should be developed for identifying claims requiring medical review. Ideally, the criteria should be developed in such a way that they may be programmed into a computer and should avoid subjective personal bias in the identification of claims as completely as possible.

TABLE 7
PROBLEMS IN PEER REVIEW

1. Selection of the physicians to conduct the review.
2. Identification of the cases for review.
3. Consistency in review decisions.
4. Legal protection for the rights of:
 - a. The individual physician.
 - b. The physicians conducting the review.
5. Review of the carriers.
6. Availability of statistical data regarding medical services.

3. *Consistency in Review Decisions:* It is very difficult for an individual consultant to be consistent over a period of time regarding even a single type of case. It is impossible to expect several consultants to make a consistent recommendation regarding any type of claim. If decisions and recommendations are to be made consistently it is necessary that policies or standards be available. Such policies should permit flexibility in the decisions regarding any specific case or physician. They should provide the general guidelines, however, upon which a number of physicians may evaluate medical care over a long period of time.

4. *Legal Protection for the Rights of the Physician:* It is important that the physician who provided the service be protected in the peer review mechanism. The peer review decision should not be the basis upon which malpractice procedures may be undertaken. The physicians performing the review should have adequate legal protection. The evaluations and recommendations made in good faith by the members of a peer review committee should not be the basis upon which suits may be brought against the individual physicians or against the committee itself.

5. *Review of the Carriers:* It is reasonable for the organizations providing reimbursement for medical services to request a review of the appropriateness of the services which have been provided. For this reason, it is satisfactory for carriers, whether commercial organizations or federal agencies, to request a review of the services provided by physicians. It is also reasonable, it seems to me, that carriers should permit a satisfactory evaluation of their mechanisms for determining the liability for reimbursement for medical procedures. It should be possible for representatives of physicians and of other providers of medical services to evaluate the manner in which carriers have determined their liability. The manner in which the carriers have determined the usual, customary and reasonable charges for medical procedures should be available for review by such physician representatives. The manner in which carriers handle complaints from physicians or from patients should be a matter of on-going cooperation between the providers and the carriers. It is desirable that communications between carriers and patients be worded with diplomacy. It is also desirable that carriers provide knowledgeable and courteous individuals for a discussion with providers of differences of opinion in decisions which have been made.

6. *Availability of Statistical Data Regarding Medical Services:* It is desirable that the physicians responsible for the peer review decisions have control of the statistical data upon which these decisions

have been based. If it is not possible for the statistical data to be controlled by the peer review committee, the statistical data should be available to the peer review committee. If the statistical data is not available, it may be impossible to verify or to deny satisfactorily allegations that improper medical services have been permitted by a peer review committee or organization.

As indicated earlier, it is necessary that objectivity be developed in the peer review mechanism (Table 8). The selection of patients, of claims or of

TABLE 8	
OBJECTIVITY IN THE GUIDES FOR REVIEW	
1.	The individual claim.
2.	Patterns of practice.
3.	Containment of the cost per unit of service:
a.	Usual, customary, reasonable.
b.	Relative Value Studies.
4.	Prevention of over- or under-utilization:
a.	CHAP.
b.	Review of claims exceeding (or below) established limits of utilization.
5.	Consistency in review decisions:
a.	Policy Manual.
6.	Guides by the medical specialties regarding the quality of medical care.
a.	ACOG indices for use in the peer review of obstetric and gynecologic procedures.

physicians for specific review should be determined by objective methods. It is preferable that the selection be made by proper programming of computers for the electronic data processing of claims. Such a method of programming permits rapidity and objectivity in the identification of individuals or of claims for review.

The evaluations and recommendations regarding medical services should be made with objectivity as far as possible. It is desirable that policy manuals or standards be developed which can serve as a general guide for evaluating medical services. Though no general policy is completely applicable to any individual case, such guidelines will permit a greater uniformity in the decisions which are made by many individuals involving a relatively long period of time.

It is rarely practical to provide peer review on a single claim. Almost any individual service or procedure may be justified for an isolated individual patient. The appropriateness of the diagnostic tests and therapeutic measures may be evaluated as they relate to the diagnosis which has been recorded. The reasonableness of the charges may be identified as they relate to the recorded information.

Satisfactory peer review can best be done as patterns of practice are determined and compared. The information should be available from all of the carriers involved, commercial or governmental.

Computers should be properly programmed for

the proper input of data and the retrieval of necessary information. The programmed information may include hospital care or other institutional treatment combined with ambulatory care. The diagnostic and therapeutic procedures may be identified and the frequency of the services recorded. The number of physicians involved by the patient in the treatment of the condition may be determined. The duration of therapy whether hospitalized, institutional or ambulatory may be determined. The total cost per patient per year per diagnosis could be identified. Statistical comparisons should be available for the treatment of comparable conditions by peer physicians.

The wage price freeze has rather effectively stabilized charges for physicians' services. A comparison with the usual customary and reasonable charges of the community of physicians also serves as another mechanism for evaluating the charges which have been made per unit of service. The relative value studies may also serve additionally in evaluating the charges for medical care.

Various mechanisms have been proposed to prevent over- or under-utilization of medical facilities and services. Mechanisms such as that of the Certified Hospital Admission Program (CHAP) are being studied to determine whether or not they can permit the proper hospitalization of patients for medical services. The in-hospital evaluation of the patients under these programs can also aid in avoiding extended hospitalization beyond the time advisable for satisfactory patient care.

It is possible to establish parameters identifying the limits of utilization which will be acceptable. These may designate a limitation on the number of visits as well as the type and amount of diagnostic and therapeutic measures which may be acceptable. Claims exceeding these limits may be identified for individual review. Patterns of practice may be established utilizing such parameters. Individual physicians whose patterns of practice persistently exceed the designated parameters may be placed under an ongoing surveillance of their medical services.

Consistency in Review

It is desirable, as mentioned previously, that a policy manual be developed which may be based in part upon medical opinions from those individuals or organizations who are accepted as authorities in the area involved. The policy manual may also include the decisions by the peer review organization which have been identified as ones of policy. Such decisions should be utilized consistently in the review of future claims similar to the ones upon which the initial policy decision was based.

Many of the medical specialty societies or organizations are developing guidelines for the most frequent medical services relating to the individual

TABLE 9
SPECIFIC CAUSES FOR UNUSUAL
PATTERNS OF PRACTICE

- 1. Differences in medical opinions and in judgment.
- 2. Ignorance and/or incompetence.
- 3. Inappropriate care, including over- and under-utilization of medical services.
- 4. Excessive charges for medical care.
- 5. Over-utilization by the patient.
- 6. Fraud.

specialty. The American College of Obstetricians and Gynecologists published in September 1973 a guideline entitled, "Indices for Use in the Peer Review of Obstetric and Gynecologic Procedures."

It is anticipated that guidelines established by medical specialty organizations will be modified and adapted for local utilization. One very valuable teaching application of guidelines is to have an individual medical staff of a hospital or of a local specialty organization develop what it considers satisfactory guidelines for any specific procedure within the range of that specialty. The development by the organization of its own specific guidelines will be helpful for the local medical community. It will also indicate to the physicians the importance and the difficulties in developing satisfactory guidelines for any specific medical condition.

The educational aspects of peer review are directed toward the improvement of the quality of medical care provided by the entire medical community. The educational activities may be directed more specifically toward a geographic region, toward an individual hospital situation, or toward the practice provided by an individual physician. Most physicians are prepared to modify their medical care of a patient as soon as they have been informed that the treatment generally accepted as correct for the specific condition is at variance with the treatment the physician has provided for such a case. An occasional physician fails to modify his pattern of practice in spite of recommendations which may have been made to him in an effort to obtain a modification of the treatment which he has provided. In Table 9 are listed some of the specific reasons accounting for physicians who may be providing unusual patterns of practice. Specific educational programs should be developed to involve such physicians. The educational programs should enable almost all physicians to respond and to provide medical care of high quality within a reasonably short period of time.

Again, I should like to express my appreciation to you for the opportunity of meeting with you today. The Seminar on Professional Standards Review Organizations is a most timely conference.

17 Prescott Street, N.E. 30308

Efficiency, economy and controllability are three of the reasons cited for this proposal that Georgia be designated as a single, state-wide PSRO area.

Recommendation for PSRO Area Designation

C. E. BOHLER, M.D., *Brooklet**

GOOD MORNING, I am Dr. Emory Bohler, President of the Medical Association of Georgia. I would like to thank Dr. Hudgins for giving me the opportunity to present this proposal on behalf of the MAG and its 4,000 members.

Although most of us here are aware of MAG's position on PSRO, I would like to make a comment on it for the record. The majority of our physicians are greatly troubled by PSRO and have grave reservations concerning MAG's participation in PSRO activities. This was adequately demonstrated by the action of our House of Delegates this past May. However, at the same time the MAG Executive Committee was instructed to "offer constructive input in developing guidelines for the operation of the program."

That is precisely why we are here today presenting this statement which has been approved by the Executive Committee of Council of MAG.

My purpose is to present a proposal for the designation of Georgia as a single, state-wide PSRO area with regional organizations and within them local medical review organizations. In order to present the MAG's thoughts adequately, we have found it necessary to add some substance to the skeleton of the proposal for geographical areas.

Why A Statewide PSRO

First, the reasoning behind our support for a single, statewide PSRO for Georgia: in reviewing the HEW guidelines available at this time, we find no reasonable way in which the State can be divided into multiple PSRO areas with any expectation of successful operation within a reasonable time.

Georgia is a geographically large, basically rural state. Trying to group physicians as the guidelines suggest would in effect destroy the medical service areas that exist, with the exception of the metropolitan Atlanta and Augusta areas which do have in ex-

cess of the 300 minimum physicians that the guidelines call for. Designation of MADOC, comprehensive health or health district areas does not reflect the actual state of medical referral areas and results in either excessively large geographical areas, areas with an insubstantial number of physicians or areas with such a wide disbursement of physicians that effective review activity would not be local and administrative efficiency would be impossible.

The MAG proposal on the other hand suggests a central administration to support local review units through regional organizations whenever necessary. This concept will provide efficiency with economy of scale while assuring local professional review.

Suggested Local Areas

Map 1 indicates the suggested areas in which local medical review organizations might function. Each of these 24 areas has at a minimum 35 physicians. The metropolitan areas of the State will serve as centers for the regional organizations' PSRO activities. The regional boundaries are indicated on Map 2. Both area maps have been sent to all MAG component county medical societies. Those that have had an opportunity to make a decision, and this includes county medical societies representing approximately 85 per cent to 90 per cent of the total membership, have indicated their concurrence with the boundaries with some minor adjustments still to be made.

We believe that the suggested PSRO of Georgia promotes local review by supporting organizations which have an awareness of local health services, facilities and practices while removing the burden of operating an administrative organization. The regional structure will provide a broader range of medical specialties and provide administrative support if desired by the region. The state PSROG would coordinate the collection and reporting of data and management of the data system at the state level with options for regional data systems.

A state-wide, umbrella agency in Georgia would

* As President of the Medical Association of Georgia, Dr. Bohler presented this proposal at the PSRO Area Designation Hearing August 30, 1973 at the Medical Association of Atlanta building.

facilitate communication between the Medicare and Medicaid programs and the PSRO. Additionally the proposed state organization offers expanded participation for non-physicians in order to allow hospital administrators, nursing home administrators, insurance representatives, state government and the public a voice in assessing the economy, efficiency and quality of medical services provided in the institutional setting.

Our understanding of the PSRO law and recent decisions made by the national PSRO Council reaffirm our belief that a state-wide PSRO in Georgia is not only the most practical approach but, in fact, is entirely consistent with the law. Furthermore, I believe PSRO's will be able to function properly only if they are allowed to develop along lines which the physicians of each state desire.

MAG's Peer Review History

In our state we believe PSROG will best serve all of us. Second, let me briefly mention the experience the MAG has had in the area of peer and utilization review.

For many years the Medical Association of Georgia has been deeply concerned with the problems of medical care delivery, its cost and its quality. As an expression of MAG's concern, the Association has become progressively involved with a number of innovative programs such as CHAMPUS (Military Medicare, 1956), Georgia Regional Medical Program (1967), Georgia Medical Care Foundation (1970), and the Experimental Medical Care Review Or-



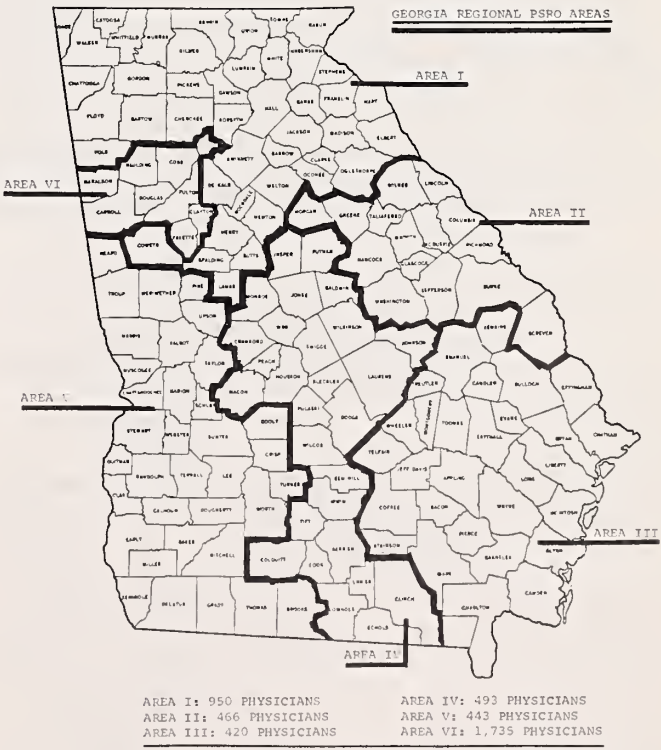
MAP 1
Local Medical Review Organizations Areas

TABLE I	
PSRO OF GEORGIA BOARD OF DIRECTORS	
The PSROG Board Shall Be Comprised of 32 Members:	
20	Doctors of Medicine
2	Doctors of Osteopathy
2	Hospital Administrators
1	Nursing Care Facility Administrator
2	Medicare Intermediaries (Blue Cross/Blue Shield)
1	Health Insurance Council Representative
2	Public Members
1	Representative for the State of Georgia Department of Human Resources
1	Medicare Carrier (Prudential)

ganization (EMCRO, 1971). The activities of these organizations are detailed in our written proposal.

At this time I would like to describe the proposed functioning and structure of the PSROG.

Medical norms of care will be developed through PSROG by committees of M.D.'s and D.O.'s representative of the geographical regions of Georgia, and will be modified and endorsed by each region to assure the appropriateness of the norms for that region. The complete medical review function will be delegated to regional PSRO's composed entirely of M.D.'s and D.O.'s, and the administrative functions will be delegated to those regional PSRO's which are able and willing to accept this responsibility. The PSROG includes representation on its board of directors of all of the organizations involved in the delivery of health services to the citizens of the State of Georgia, comprised as you can see in Table I.



MAP 2
Regional Boundaries for PSRO Areas

The PSROG board will establish a central coordinating committee to function as the prime policy making organization. Other committees formed by the board and responsible to the central coordinating committee will be a physician advisory committee, an insurance advisory committee, a data evaluation committee, and a consumer forum on health care. Six regional Professional Review Organizations will be established within Georgia. The purpose of these organizations will be to provide the peer review activities required of PSRO on a regional basis. This approach allows for review within a medical service area, drawing from the resources of an entire section of the state, while maintaining statewide uniformity to the review procedures, data collection, administration, and criteria.

The structure of the regional PSRO will be determined either by local review organizations currently performing PSRO-like activities, or by the PSROG board. It is the intent of PSROG to subcontract professional review activities to the regional PSRO's. PSROG will also subcontract administrative functions of PSRO to regional organizations which are capable and willing to undertake these activities. Diagram I will give you an idea of the proposed structure.

Regional PSRO's will designate and establish local medical review organizations. Using standards established by PSROG, the regional PSRO's will monitor the performance of local medical review organizations and hospital utilization review committees and provide assistance to these organizations as required. Based on this monitoring function, the regional PSRO will determine if a hospital utilization review

committee is performing adequately enough to be authorized to perform their own in-hospital review.

The regional PSRO will review data generated by PSRO and can recommend changes in criteria. They will implement such educational programs as identified and developed by PSROG.

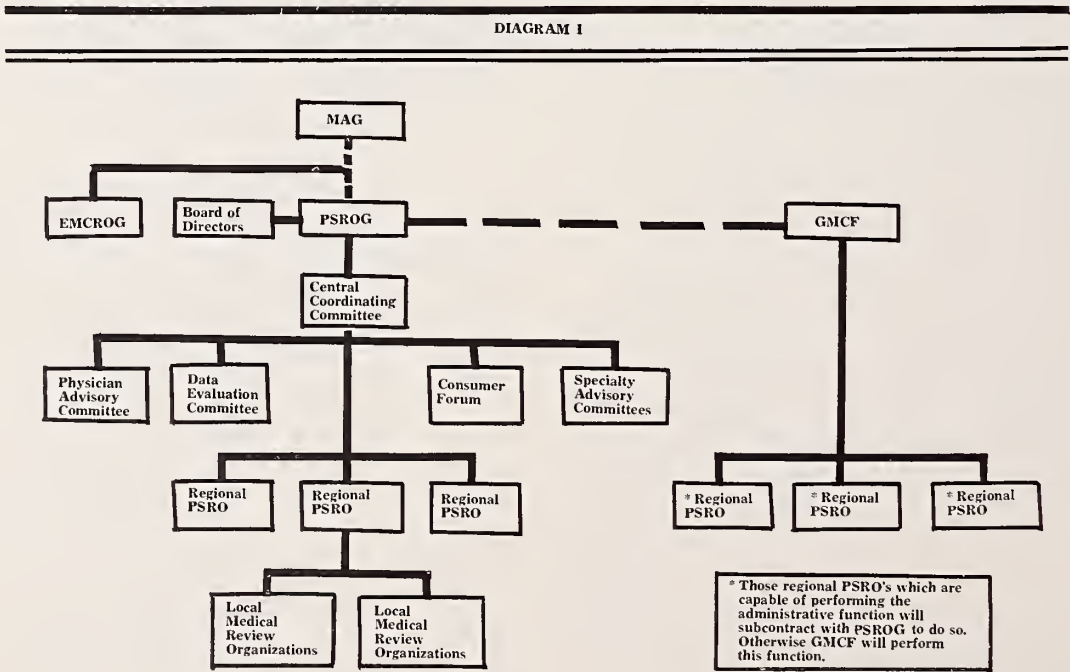
The local medical review organizations provide local physician input into PSRO activities. Local medical review organizations will be established as designated by the regional professional review organizations.

Local medical review organizations will perform the medical review functions in accordance with PSROG general standards and guidelines. Decisions of local medical review organizations on individual cases will *not* be subject to further medical review except on appeal by the patient or the institution or physician(s) who has provided the care. They will refer variances in local practice to PSROG through the regional PSRO for suggested modification of current standards.

Hospital Utilization

Hospital utilization review committees will develop procedures designed to meet program standards, and implement such procedures. Upon evaluation and determination that performance standards of PSROG are achieved, the hospital URC may qualify as a local medical review organization with full responsibility for in-hospital review decisions.

In conclusion, I would first say that through activities such as the Georgia Medical Care Foundation and EMCRO, the MAG has been instrumental in establishing effective, operational mechanisms for review of the utilization, cost and quality of medical care on a state-wide basis. By decentralizing these functions, PSROG could rapidly establish an eco-



nomic, efficient and controllable system of review using its available manpower and other resources.

Second, acceptance of the state-wide umbrella PSRO model would serve the department of HEW better than a number of fragmented PSRO's in Georgia. Certainly administrative expenses both centrally at HEW and in the regional HEW offices should be less since fewer personnel would be required. HEW could expect more rapid response to changes in rules and regulations by a single organization than through multiple organizations. Of major benefit to the federal government would be greater ease of data collection, development of statistics and comparison of norms of care through the single state PSRO.

Third and perhaps most important, if we must

live with PSRO, the practicing physicians would be more willing to accept the localization of peer review activities made possible by the state-wide approach. The development of norms of care by physicians could be accomplished with consistency through the PSROG, thus avoiding conflicting norms and duplication of effort. The ultimate benefit to providers—continuing medical education—could best be coordinated and activated through a state-wide PSRO.

In view of these benefits, it is my hope and that of the MAG that the Department of HEW will favorably consider this proposal and allow designation of Georgia as a single, state-wide PSRO area.

Thank you for your attention.

Box 8 30415

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

August 26, 1973

Appointments: Committee on Communications—Jerome B. Blumenthal, M.D., Marietta; Leon E. Curry, M.D., Metter. Committee on PSRO—Thomas G. Douglass, M.D., Augusta. Committee on Emergency Medical Services—Charles R. F. Baker, Jr., M.D., Atlanta; S. P. Hartley, M.D., Riverdale. Ad Hoc Committee to Study MAG Functions—W. E. Barron, M.D., Newnan. Committee on Membership—Harry C. Sherman, M.D., Augusta; David M. Boyette, M.D., Albany. Chairman Task Force on Continuing Education—Richard E. Thompson, M.D., Columbus.

Nominations: Medical Board of Workmen's Compensation—SURGERY—Walter E. Brown, M.D., Savannah and Thomas S. Howell, M.D., Atlanta; PATHOLOGY—John T. Godwin, M.D., Atlanta and Menard Ihnen, M.D., Augusta; RADIOLOGY—Richard A. Elmer, M.D., Atlanta and Robert B. Quattlebaum, M.D., Valdosta; DERMATOLOGY—Chenault W. Hailey, M.D., Atlanta and Vincent J. Cirincione, M.D. Pharmacy Advisory Committee—Stanley P. Aldridge, M.D., Decatur; Joseph M. Almand, M.D., LaGrange; Luther G. Fortson, M.D., Marietta.

MAG Insurance Program: Received report from MAG Committee on Insurance and Economics recommending cancellation of Life of Georgia plans and en-

dorsing Southern Medical Association insurance plan.—Referred to Council.

WATS Line: Direct telephone service from any point in Georgia to MAG becomes available approximately October 1 by dialing 1-800-282-0224.

Acupuncture: Discussion on decision of Georgia Attorney General defining acupuncture as a medical procedure. Referred to Private Practice Committee question of third-party reimbursement of acupuncture.

Medicare Hearing Procedure: Recommended to Richmond County Medical Society that resolution be presented to Council regarding "unfairness" of Medicare hearing with referral to AMA House of Delegates.

Foundation: Received report on progress of Nursing Home "on-site" Review Program and preparation of proposal for concurrent review program (CHEC) in hospitals for possible implementation October 1.

PSRO: Approved a proposal to help prevent the HEW Secretary from splitting Georgia into multiple PSRO districts. Under this plan peer review would function at the local level.

EMCRO: Received report on expected participation of five hospitals around state in Hospital Discharge Abstract System and continued testing of Nursing Home System in 30 homes.

A workable plan is described in the campaign against this increasing problem.

Gonorrhoeae: Control Through Culture and Counseling

VIRGINIA P. McNAMARA, M.D., ARMAND B. GLASSMAN, M.D., WILLIAM A. SCOGGIN, M.D.
and EDWIN S. BRONSTEIN, M.D., *Augusta**

VENEREAL DISEASE CONTINUES to be an increasing problem in almost all sections of the United States.⁶ Georgia and particularly Richmond County have consistently had very high attack rates. In an effort to control the problem in the Outpatient Clinic of the Obstetrics and Gynecology Department of the Medical College of Georgia and to prevent disease in the newborn, a mass screening program for the detection of gonorrhoeae, utilizing the Thayer-Martin Culture Medium was begun in late 1971. Thayer-Martin is a commercial medium supplemented with a chemically defined enrichment that has been tested for the primary isolation of *Neisseria gonorrhoeae*.⁶

The OB-GYN Outpatient Clinic of the Medical College receives referrals from the entire state of Georgia, with the majority of patients coming from the eleven counties surrounding Augusta. Many patients must make a 100-150 mile round trip to visit the clinic. Ninety percent of the women are black and 40 percent of the total are in the "teenage category." Many of these are unmarried school girls. The clinic serves largely a low income population.

Methods and Materials

Prior to July of 1971, screening for gonorrhoeae was performed by gram stains. Accumulated data points up the inadequacies of this method of gonorrhoeae control. More definitive information and a higher percentage of affected patients will be picked up with use of Thayer-Martin Medium. This was designed for selectivity and sensitivity in the detection of *Neisseria gonorrhoeae*.^{2, 3} After initial isolation, presumptive and definitive identification is carried out, including:

1. Typical colony morphology

2. Positive oxidase test
3. Gram stain on oxidase positive colonies
4. Definitive glucose fermentation or fluorescent antibody (FA) staining methods which specifically identify positive colonies as *Neisseria gonorrhoeae*.³

The FA procedure has been found to be reliable, easier and less time-consuming than the fermentation method in our hands.

Education and indoctrination resulted from close communication between the laboratory staff and clinic personnel. Although our working relationship with the laboratories results in better yields with Thayer-Martin plates, outlying health department clinics are using the Transgrow bottles available from the Venereal Disease Unit of the Georgia Department of Human Resources and the Hyland Company. Problems that we found with the Transgrow bottles included:

1. Greater difficulty for personnel to handle
2. Greater difficulty in reading colony morphology
3. Increased propensity to moisture formation

The following groups of patients were selected for cultures:

1. New obstetrical patients
2. Obstetrical patients at 32 to 34 weeks gestation
3. Postpartum patients at the time of the six weeks visit
4. GYN patients suspected of gonorrhoeae

Cultures were obtained in the following manner:

Cervical Culture: Techniques for obtaining cultures were followed as recommended in the publication, *Criteria and Techniques for the Diagnosis of Gonorrhea*, Department of Health, Education and Welfare, Center for Disease Control, State and Community Services Division, Venereal Disease Unit, Atlanta, Georgia.¹

Sites From Which Cultures Taken: In the clinic setting, the majority of cultures were obtained from

* Each of the authors is a faculty member of the Medical College of Georgia: Dr. McNamara is assistant professor in the Department of Obstetrics and Gynecology; Dr. Glassman serves as Director of Laboratory Medicine; Dr. Scoggin is professor and chairman of the Department of OB-GYN; and Dr. Bronstein is an associate professor and chief of the Section on Maternal Health and Family Planning of the OB-GYN department.

the cervix with some being obtained from the anal canal, some from the urethra, and a small number from the vaginal vault (i.e., children and hysterectomized women).

The technique for inoculating Thayer-Martin Medium was followed as described in the previous reference.¹

Culture results are reported in two to four days. Patients with positive cultures are treated and then re-cultured two weeks later.

Recommended Treatment Schedules for Gonorrhea—March 1972, from the U.S. Department of Health, Education and Welfare Center for Disease Control, Venereal Disease Branch, Atlanta, is as follows:⁴

“PARENTERAL—Men or Women: Aqueous procaine penicillin G, 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to the injection.

or

ORAL—Men or Women: Ampicillin, 3.5 grams, with probenecid, 1 gram, administered simultaneously.

Treatment of contacts: Patients with known exposure to gonorrhea should receive the same treatment as those known to have gonorrhea. When penicillin or ampicillin is contraindicated, or when the above schedules are ineffective:

PARENTERAL—Men: Spectinomycin, 2 grams, in one intramuscular injection. Women: Spectinomycin, 4 grams, in one intramuscular injection.

or

ORAL—Men or Women: Tetracycline HCl, 1.5 grams initially, followed by 0.5 gram four times a day for 4 days, a total dosage of 9 grams. Other tetracyclines are not more effective.”

Tetracycline is not given to pregnant women allergic to penicillin, due to possible potential effects on the fetus. Such patients are given erythromycin because spectinomycin has not been adequately studied in terms of potential damage to the fetus. For non-pregnant patients allergic to penicillin, we use either tetracycline or spectinomycin.

Discussion of Table

To date, 2615 cultures have been done. Of those positive, 153 of 184 received treatment. Thirteen of these represented reinfection. Treatment was necessary in some patients, two to three times. No definitive reason for this is apparent, but may represent organism resistance, inadequate treatment of partners or new contacts.

Despite an effort to education our patients regarding venereal disease, the reinfection rate is 7 percent.

TABLE 1
GONORRHEAL INFECTION—TREATMENT AND REINFECTION: SELECTED OB-GYN PATIENTS OF MEDICAL COLLEGE OF GEORGIA
January-December 1972

	Patients	Positive	Un-	Re-	
	Cultured	Cultures	Treated	treated	
				Infected	
January	230	25	16	9	4
February	200	11	7	4	1
March	278	15	13	2	1
April	156	13	11	2	2
May	233	24	22	2	2
June	164	11	10	1	1
July	207	11	9	2	0
August	248	13	12	1	0
September ...	207	18	16	2	1
October	256	21	19	2	0
November	260	14	13	1	1
December	176	8	5	3	0
Totals	2615	184	153	31	13

This may be a failure to communicate the importance of limiting sexual activity until healing can take place or a failure to create sufficient awareness regarding the necessity for sex partner or partners to be treated. A continuing problem in a woman-oriented clinic (such as the one under present discussion) is treatment of the male, a very important part of the epidemiologic picture. To deal with this problem, we have received excellent cooperation from the Venereal Disease Unit of the Richmond County Health Department and East Central Health District. Health Program Representatives now trace contacts back into the counties of the patients' residence and treat them. In some instances, specially funded programs are permitting treatment of contacts in the private physician's office. For those unable to pay, the local health departments are now able to reimburse the local physician. It is hoped that these measures will expedite treatment for low income males and females who might otherwise not be treated.

A Multiple Health Problem

Gonorrhea is a significant health problem which represents health hazards not only to the mother but the fetus as well. In Richmond County, Georgia there is a high incidence of gonorrhea. In an effort to effectively diagnose and treat this condition with eventual health benefits to a broad patient population, a study utilizing presumptive and definitive culture techniques, appropriate therapeutic modalities and the enlisted aid of local and county health officials has been undertaken. In a one year period of time, we have found that our infection rate on cultures in a defined population is positive in seven percent. Eighty-three percent of those patients with positive cultures have been given a course of treatment which would appear to be adequate. Despite

adequate therapy, seven percent of our patients have returned with reinfection. Only through continuing efforts of education, communication and interaction with community health officials can this percentage be further lowered. It has been our policy to instruct patients in the transmission of the disease, aspects of proper therapy, possible hazards to their health and health of their children and the necessity for treatment of sex partner or partners.

It is our goal to continue this program for the detection of gonorrhea and to strengthen our working relationship with the health care delivery personnel of the Venereal Disease Unit of the East Central Health District as well as other districts of the Georgia Department of Human Resources. It is our opinion that this approach will result in a more successful and satisfying outcome in the campaign against gonorrhea.

The myth of symptomatology forcing a patient to obtain medical treatment is being rapidly dispelled with increasing information in the literature reporting a significant percentage of male and female infected patients are without symptoms and/or knowledge of the disease presence.^{5, 6} Only with an effective culture program such as the one described using Thayer-Martin Medium can these "silent cases" be detected and taken from the possible reservoir pool to halt promulgation of the disease.

Medical College of Georgia 30902

Acknowledgements

We would like to acknowledge the assistance of Mrs. LouEllen Noble, laboratory technologist in the Torpin Clinic of the Medical College of Georgia.

We also wish to express appreciation to Dr. William Brown, Venereal Disease Unit, Division of Chronic Diseases, Georgia Department of Human Resources, for his review of this paper.

Mr. George Morrell, Health Program Representative, and his staff at the Richmond County Health Department (East Central Health District), have been excellent co-workers in our efforts to locate, educate, and treat patients in Richmond County and the 10 counties surrounding Richmond.

Mrs. Ann Beggs, Secretary with the Maternity and Infant Care Project, has been most helpful in typing and editing the paper for publication.

Finally, the authors would like to recognize the untiring efforts and cooperation of the entire staffs of the Outpatient Clinic, Department of Obstetrics and Gynecology and the Central Laboratory of Eugene Talmadge Memorial Hospital.

REFERENCES

1. *Criteria and Techniques for the Diagnosis of Gonorrhea*; Department of Health, Education and Welfare, Center for Disease Control, State and Community Services, Venereal Disease Branch, Atlanta, Georgia.
2. Frankel, Sam, Reitman, Stanley and Sonnewirth, Alex C.: *Clinical Laboratory Methods and Diagnosis* (Gradwohl); St. Louis, Mo., C. V. Mosby, 2:1193, 1970.
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4. *Recommended Treatment Schedule for Syphilis and Gonorrhea*; Venereal Disease Unit, Division of Physical Health, Georgia Department of Human Resources, Aug. 28, 1972.
5. Thatcher, R. W., McCraney, W. T. and Kellogg, D. S., Jr.: Asymptomatic gonorrhea; *JAMA*, 210:315-317, 1969.
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FLAME FREE DESIGN CONFERENCE ATTRACTS VARIED PROFESSIONALS

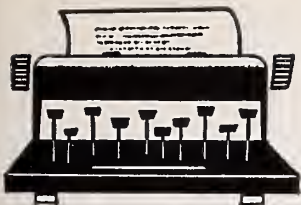
Members of many professional disciplines concerned with the complex problems involved in fire and burn accidents, 75 per cent of which are avoidable, will meet in Atlanta March 13-15, 1974 for the 3rd National Flame Free Design Conference.

Some 500 to 600 physicians, nurses, attorneys, merchandisers, media personnel, fiber and fabric manufacturers and fire chiefs hope to come up with ways of reducing the cost of fire accidents which is high in lives and dollars.

The conference will concentrate on the problems of respiratory heat damage, inhalation injury, flame-re-

tardant construction of private and public buildings and the problem of convincing the public to demand flame-free materials.

A registration of fee of \$75 is asked and will cover the cost of most meals, including a Flame-Free Fashion show featuring clothing of flame-retardant materials. For additional information, contact Carl Jelenko, III, M.D., chairman of the Local Arrangements Committee at the Department of Surgery, Medical College of Georgia, Augusta, Georgia 30902; or, Mr. R. A. Kolvoord, Conference Coordinator, Designers Group, Inc., 4101 North Freeway, Houston, Texas 77022.



Medical Association of Georgia WATS Line 1-800-282-0224

WHAT IS WATS LINE? Wide Area Telephone Service. It is a toll-free telephone line which enables you to call MAG Headquarters in Atlanta from anywhere in the State of Georgia.

But, we hope the MAG WATS line will be more than a telephone number to you. It is your invitation to participate in the Medical Association of Georgia. You are MAG.

Beginning in October, 1973, pick up your telephone and share your great ideas, likes and dislikes with us.

There is no problem facing medicine today that together we can't solve. Don't be an isolationist—get with us.

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The Need for a Special Session Emerges

DURING THE 1973 MAG Annual Session, a recommendation was proposed and adopted by the House of Delegates to consider having a special session of the House to hear a report, and subsequently approve or disapprove the Georgia EMCRO project. If the EMCRO is to become operational, the approval of the MAG House of Delegates must be given for its activities.

EMCRO personnel report that they expect the program's experimental activities to be ready for operation by January 1, 1974; consequently, the need for the December special session of the House. A report and recommendations from the MAG Committee on EMCRO will be presented to the House of Delegates.

In a subsequent action, the PSRO Committee of MAG suggested to the Executive Committee of Council that the subject also be placed on the agenda of the special session, if only for educational or informational purposes.

Please note that discussion and debate will be limited to these two subjects alone: EMCRO and PSRO.

The House of Delegates will meet as a Committee of the whole, rather than using the reference committee structure. Reports and resolutions will be presented and considered by the entire House of Delegates. A member wishing to offer a resolution or report to the House should go through his county medical society or a delegate to the House.

Additional information concerning the special session will be made available to the officers of the county medical societies and to the delegates and alternate delegates of the House of Delegates. Members interested in attending the special session of the House are urged to make reservations early at the Marriott Hotel in Atlanta. Delegates, officers and councilors will be mailed special Marriott room reservation cards so they may be assured of a room at the headquarters hotel.

The interest and involvement of all MAG members is solicited for this important special session of the House of Delegates.

Harrison L. Rogers, Jr., Speaker

OFFICIAL CALL

To the officers and members of the **MEDICAL ASSOCIATION OF GEORGIA** for a special session of the House of Delegates December 15-16, 1973 at the Marriott Motor Hotel in Atlanta, Georgia.

To Consider:

**Experimental Medical Care Review Organizations (EMCRO),
and
Professional Standards Review Organizations (PSRO)**

SCHEDULE

Saturday, December 15, 1973

- 8:00 a.m.—Registration opens
- 9:00 a.m.—First Session, House of Delegates
 - Remarks of the Speaker
 - Presentation of reports and resolutions on EMCRO
 - Report on findings of the Committee on EMCRO
 - Discussion period
 - Recess
- 12:00 p.m.—County medical society caucus luncheons
- 2:00 p.m.—Reconvening of the House of Delegates
 - Discussion period
 - Voting
 - Adjournment

Sunday, December 16, 1973

- 9:00 a.m.—Second Session, House of Delegates
 - Remarks of the Speaker
 - Presentation of reports and resolutions on PSRO
 - Report of the Committee on PSRO
 - Information and discussion period
 - Recess
- 12:00 p.m.—County medical society caucus luncheons
- 2:00 p.m.—Reconvening of the House of Delegates
 - Discussion period
 - Voting
 - Adjournment

Delegates' materials, registration information and room reservation cards at the Marriott Hotel will be mailed to all members of the House of Delegates.

C. Emory Bohler, M.D., *President*
Harrison L. Rogers, Jr., *Speaker*
Ernest C. Atkins, M.D., *Secretary*



ROUND ONE

WE HAS MET THE ENEMY and he ain't us!

On August 30, 1973 at the Medical Association of Atlanta building on West Peachtree in Atlanta, we presented to Mr. Eddy Sessions of the regional office, Department of Health, Education and Welfare, our position and feelings concerning the division of the State of Georgia for Professional Standards Review Organizations. Your Council and Executive Committee feel that Georgia should be one PSRO area and we feel this falls within the guidelines of the PSRO law.

Mr. Sessions informed us in no uncertain terms *before* we were allowed to present our views that he would recommend to Secretary Weinberger that Georgia *not* be allowed to exist as only one PSRO area. Needless to say, our spirits were considerably dampened by his remarks and attitude.

After our presentation, and supporting presentations by other organizations, we were again informed that we had not influenced Mr. Sessions' feelings concerning the State of Georgia and PSRO.

My remarks and MAG's presentation and recommendations are published elsewhere in this issue of the *Journal*. At this time, we have not been informed as to how Mr. Sessions will recommend the state be divided.

A handwritten signature in cursive script, reading "Charles E. Bohler, M.D.".

Charles Emory Bohler, M.D.
President, Medical Association of Georgia



CLINICAL MANIFESTATIONS OF PERIPHERAL ARTERIAL DISEASE

OLIVER W. KING, M.D., *Austell and Smyrna**

PERIPHERAL VASCULAR DISEASE is a common process affecting large segments of the older and middle age populations, inflicting pain, loss of function, and even death. Newer, sophisticated methods of diagnosis and treatment are now available to correct this disease and relieve its symptoms.

This communication will describe the major bedside and office signs which the patient is likely to present to the examining physician. Liberal use of Allen, Barker, and Hines textbook of vascular diseases has been utilized in preparing this manuscript and is recommended for further reference.

Key Process: Hypoxic Ischemia

Although arterial insufficiency has many etiologies, the vast majority of cases will be relegated to atherosclerotic obstructive disease of the major arteries. The common denominator is obstruction to flow within the tubular conduits and secondary ischemia distal to the obstructive process. No matter what organ system is involved, the key process is hypoxic ischemia to that organ system. The degree of ischemia produced is proportionate to (1) the proximal limit of the occluding process, (2) the extent of the arterial occlusion of branches of main arteries which are potential collateral channels, and (3) the rapidity of development of the occlusion.

Atherosclerotic occlusive disease attacks many organ systems. I have restricted this discussion to the signs and symptoms manifested by obstructive disease to the lower extremities.

Symptoms of Obstructive Disease

1. Intermittent claudication

Intermittent claudication, often described as an ache, cramp, numbness, or sense of fatigue in certain muscles, develops only during exercise. This distress is promptly relieved with rest and is not dependent on changes in position. Usually this is the earliest symptom of obstructive arterial disease. The obstructive lesion is almost always proximal to the muscles affected.

2. Rest pain

This symptom is evidence of far advanced disease and usually follows extensive, acute occlusion secondary to thrombosis or embolus. The pain is constant and severe and is usually more noticeable at night. Patients obtain partial relief by allowing the feet to hang in a dependent position. The pain tends to be localized to the toes and feet, but the more proximal legs may also be affected.

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

3. Pain of ulceration and gangrene

The pain is similar to rest pain, but involves only the area of tissue necrosis. Concomitant neuropathy may lessen the pain of ischemic necrosis.

4. Ischemic neuropathy

Pain from this source is usually severe and tends to extend over large areas of the involved extremity. This pain may exist for varying periods of time even after restoration of circulation has been accomplished. Likewise, disuse atrophy may occur and pain may be associated with this condition.

Osteoporosis and atrophy of skin and subcutaneous tissue occurs after long periods of ischemia and disuse. With resumption of weight bearing and use of the extremity, the resultant pain may be difficult to control.

Physical Findings

1. Impaired pulsations

This is the most important and consistent finding in patients with occlusive vascular disease. Occasionally the dorsalis pedis pulse may be absent in an otherwise normal arterial tree, but the other major arterial branches should be readily palpable. An occasional patient will be seen with typical symptoms of claudication, but normally palpated pulses at rest. These patients will almost always lose their pulses with exercise and should be examined under these conditions.

2. Postural color changes

Abnormal pallor on elevation of an extremity and rubor on dependency with slow filling of the superficial veins is pathognomonic of occlusive arterial disease. Decreased perfusion may also be evidenced by collapse of the superficial veins in the foot with the patient flat, and by a dusky mottling of the skin about the knees.

3. Temperature changes

This important sign is easily detected by palpation of the skin and comparing the degree of coolness with the other extremity or areas of normal perfusion elsewhere.

These more classical signs and symptoms are frequently accompanied by bruits, trophic changes of the veins and nails, ulceration and gangrene of digits, atrophy of soft tissues, osteoporosis, and edema of dependency—these tending to be advanced signs of obstructive disease.

Once the patient is found to have obstructive arterial disease and if surgical correction of the lesion is contemplated, then adequate arteriography should be performed. It is only with this road map that an adequate surgical correction can be obtained.

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3001 S. Cobb Drive, S.E. 30080

REFERENCE

1. Fairbain, John F., et al.: *Peripheral Vascular Diseases*; W. B. Saunders Co. 4th Ed. 1972.



LOCALITY AND THE STANDARD OF CARE IN MALPRACTICE LITIGATION

WINSTON HUFF, *Atlanta**

GENERALLY, THE QUESTION of whether a physician has been negligent in the practice of his profession (or has been "guilty of malpractice" as it is sometimes stated) is a question of peer judgment: generally it requires the testimony of some other physician that the defendant's practice did not comport with the level of care and skill of the profession. The question remains whether the defendant is to be measured by the standards of the profession as it is practiced in his locality, as it is practiced in similar localities, or as it is practiced generally throughout the country.

Judged Against Community Standards

Under the so-called "locality rule," the physician is to be judged only by the standard of medical practice prevailing in his locality. A corollary to the rule requires that only those physicians able to demonstrate familiarity with the local standard be permitted to testify as expert witnesses.

The "locality rule" was introduced into the American common law during a time of some regional disparity of medical practice. Its origin is often traced to a decision in Massachusetts in 1880. In *Small v. Howard* (128 Mass. 131), the Massachusetts court held that a practitioner in a rural community could not be held to the standards of an urban practice. By 1930, most American jurisdictions had adopted some form of a locality rule.

In recent years, however, the rule has come under increased attack as an out-moded concept. Consideration of advanced means of communication and transportation, increased availability of medical journals and seminars, and improved training facilities for physicians have led many jurisdictions to modify or even to abandon the rule. Other courts and writers have observed that even if gaps between rural and urban practice persist, the rural practitioner should have at least the duty, where practicable, to inform his patient that more sophisticated treatment is available elsewhere. In 1968, Massachusetts itself abolished its locality rule by overruling *Small v. Howard*. The Court observed, "The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases" (*Brune v. Belinkoff*, 235 N. E. 2d 793,-798).

In Georgia, the standard has always been the practice of the profession in general, not the practice in the defendant's locality. A statute dating back to the 19th Century provides:

"A person professing to practice surgery or the administering of medicine

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

for compensation must bring to the exercise of his profession a reasonable degree of care and skill" (Ga. Code Ann. §84-924).

The Georgia courts have interpreted this statute to require a general standard of care. In rejecting the contention that a local standard prevails in Georgia, the Court of Appeals has stated, "The true rule is that the reasonable degree of care and skill prescribed in the Code is not such as is employed by the profession in the locality or community" (*Kuttner v. Swanson*, 2 S.E. 2d 230,232 (1939)).

Circumstances of Locality

Although there is, then, no locality doctrine in Georgia as a rule of law, the jury will no doubt take into account the circumstances of the defendant at the time of the alleged injury in determining what was "reasonable" for his practice at that time. Therefore, the physician's locality may play a part, for it may control what equipment is available for therapy, what support personnel are available, and what specialists are available for consultation. Also, although there is no rule of evidence to bar a physician unfamiliar with the local practice from testifying for the plaintiff, the defendant's counsel can contend that such foreign witness therefore lacks insight into the situation presented to the defendant at the time of the alleged injury. As with all other testimony, the jury is free to attach to expert testimony whatever credibility it feels is due.

In summary, the legal standard in Georgia is never what is done in the defendant's locality; however, the test applied in the individual case must make allowance for the opportunities available to the defendant physician at the time and place of the alleged injury. Thus, in the jury's determination of the physician's liability for malpractice, the entire situation as presented to the defendant—including his locality—may play a part.

Eleventh Floor

C&S National Bank Building 30303

HEALTH HAZARD REPORTED IN DRUG USED FOR TRAVELER'S DIARRHEA

Americans traveling abroad are advised to avoid buying non-prescription drugs for self-treatment of traveler's diarrhea in an article in the July 23 issue of the *Journal of the American Medical Association*.

Many of these products sold in other countries contain a drug that may cause serious neurological upsets and even death, says the report by Godfrey F. Oakley, Jr., M.D., of the Center for Disease Control at Atlanta and the University of Washington Medical School at Seattle.

The offending drug is iodochlorhydroxyquin. It is sold under more than 50 different trade names throughout the world, in many countries without prescription. In the United States it is available only on prescription and is used principally to treat amebic dysentery.

Actually, these drugs do not help overcome traveler's diarrhea and should not be used for this complaint, says Dr. Oakley.

Unregulated use of products containing this drug can cause an impairment of the senses, particularly the sense of touch. More serious, they can cause eye damage that sometimes leads to blindness. In severe cases the result may be death, the report says.

"Because the drugs are sold under a large number of different trade names, an American traveling out

of the country may find it difficult to avoid being exposed to the drug if he buys any over-the-counter remedy for diarrhea. It seems prudent, therefore, to advise travelers to avoid buying any over-the-counter products," Dr. Oakley says.

UNITED WAY: IT'S WORKING

The United Way of Metropolitan Atlanta, Inc. is conducting its first six-county campaign September 17 through November 2, 1973 and hopes to heavily involve physicians and their employees.

Rockdale has now joined forces with Cobb, Clayton, DeKalb, Fulton and Gwinnett counties in the one time, money-saving campaign to help the more than 600,000 people served by 48 member agencies from 143 service centers in the metro area.

Atlanta physician Carter Smith, Jr. is chairman of the medical division of the campaign for which a goal of \$100,000 has been set. Sixteen health-related agencies are included in the 48 member agencies: American Red Cross, Cerebral Palsy Center of Atlanta, Inc., Conyers-Rockdale Arthritis Council, Diabetes Association of Atlanta, Inc., to name a few.

I've told this before

It has been suggested that we devote space in the *Journal* to non-scientific, human interest stories. Most doctors and their wives lead rich lives and have seen or experienced amusing, interesting and unusual things at home and abroad which would be of great interest to our readers.

These stories could be about animals—tame or wild—birds, insects, humans, hunting, fishing, traveling, etc., etc. Hopefully, you could relate a story you know to be true. Acceptable would be one you believe to be true.

Have a yen to see your ideas in print or share a story? Just write it up and send it in to MAG Headquarters in Atlanta. We will edit it, if necessary, to fit the space limitations we have.

Doctors and their wives are good story tellers. Share some with your contemporaries and we will all enjoy ourselves.

Former MAG President J. G. McDaniel is helping us with this project and we have asked him to prepare a few stories. The first appears below.

Antics of a Tired Snake

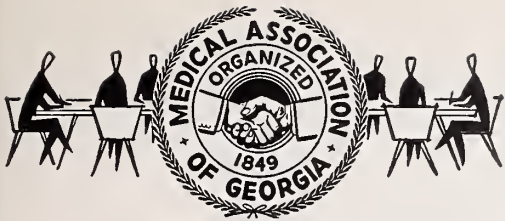
Two of us had been fishing since daylight and had “knocked off” early because the fish were not cooperating with us. We were on a rather large body of water, it was calm and I spotted a large snake swimming along crossing our bow. I told my partner to slow the motor, see if he could pull alongside the snake and I would hit him with my paddle.

We were close enough for me to identify him, just as he dived, as a moccasin about three feet long. Now, I had always heard that a snake could not stay under water very long. He had to come up for air, and since we were 200 yards from shore, we elected to find out.

Accordingly we cut the motor and commenced watching for the snake to surface. Within a few minutes he did about 50 feet toward the shore and started swimming rapidly in that direction. We cranked the motor, went around between him and the shore, got near him and he dived again.

Each time this episode was repeated, the time he remained under water became shorter and shorter. Finally it was apparent that he was frantic, completely exhausted, could not dive any more. And as I sat there watching him, he swam toward the boat—my end at that—and tried to crawl up the side. This put me at a great disadvantage in addition to making me and my cohort very nervous.

Without any coaxing, my partner cranked the motor and sped off about 20 or 30 feet. From there we watched his royal highness swim very slowly and unmolested toward the bank!



THE ASSOCIATION

NEW MEMBERS

King, Oliver W. Active—Cobb—D	3001 S. Cobb Drive Smyrna, Georgia 30080
Nora, Feliciano C. Active—FPC—Su	Floyd Hospital Rome, Georgia 30161
Pauly, Robert P. Active—Stephens—Su	800 E. Doyle Street Toccoa, Georgia 30577
Pierce, Mart T. Active—Glynn—FP	P.O. Box 1003 Brunswick, Georgia 31520
Rogers, James W. Active—Bibb—Em	777 Hemlock Street Macon, Georgia 31201
Young, R. A. Active—FPC—I	Harbin Clinic Rome, Georgia

SOCIETIES

The **Bibb County Medical Society**, at its September 6 meeting, was addressed by Jose Garcia-Oller, M.D., president and founder of the American Association of Councils of Medical Staffs of Private Hospitals, New Orleans, La. Third party invasion into the future of private practice is the concern of Dr. Garcia-Oller who spoke on the subject in Augusta last May.

Proposed plans for a retirement and investment program were presented to **DeKalb County Medical Society** members at their September 17 meeting. Panel members for the program included Duane Blair, M.D., chairman of the Investment and Retirement Committee, an attorney and an investment counseling specialist.

The **Floyd-Polk-Chattooga County Medical Society**, in cooperation with the Metropolitan Life Insurance Company's Rome office, has launched a program of providing health and safety information kits to families. The kits provide information on what to do in certain medical emergencies, a safety guide for baby sitters, details on how to reach a physician or ambulance and other valuable information.

A Symposium on Athletic Injuries August 25 in Savannah was sponsored by the **Georgia Medical Society** and the Chatham County Board of Education Athletic Department.

Front-running mayoral candidates were questioned by the press and members of the **Medical Association of Atlanta** during the regular monthly meeting of the society September 11. Families of the physicians were also invited to the dinner and debate moderated by James Kaufmann, M.D. of Atlanta.

PERSONALS

First District

Savannah's **Jane Jennings, Robert Quattlebaum, Jr., Shaw C. T. Su** and **Irving Victor** have co-authored, with Samuel A. Torres, the article, "Primary Mucinous Adenocarcinoma of the Urinary Bladder," which appeared in the September issue of *Southern Medical Journal*.

Second District

Eugene C. Jarrett has been named superintendent of Southwestern State Hospital at Thomasville and Bainbridge State Hospital in Bainbridge. Dr. Jarrett was graduated from the Medical College of Georgia and served as director of the Evaluation Center at Gracewood State School and Hospital in Augusta at the time of this appointment by the Board of Human Resources.

Third District

Gordon C. Miller of Columbus is the author of "The U-Tube Mercury Manometer for Measuring Mean Intravascular Pressure at the Bedside" which appeared in the September *Southern Medical Journal*.

Fifth District

Peter A. Ahmann has been appointed assistant professor of pediatrics (neurology) at Emory University's Woodruff Medical Center. He recently has completed a fellowship in pediatrics neurology at Emory under a program of the National Institute for Neurological Diseases and Stroke.

Charles R. Hatcher, Jr., Atlanta, took office as president of the Georgia Heart Association September 21 at the Association's Silver Anniversary Annual Meeting in the capital city. He succeeds **Curtis G. Hames** of Claxton.

Serving as chairman of the medical division of the United Way campaign professional unit is **Carter Smith, Jr.**

Surgeon **Lea Richmond** has been elected chairman of the board for the Hospital Authority of Fulton County.

Seventh District

New MAG member **Rodger H. Eidson** has joined **James R. Gregory** and **Harvey S. Wages** in the practice of obstetrics and gynecology. The Newnan native was graduated from Bowman Gray School of Medicine of Wake Forest University, interned at the Macon Hos-

ASSOCIATION / Continued

pital and completed his residency at the Medical Center of Central Georgia in Macon.

The Cobb County Hospital Authority recently honored **William C. Patterson** of Smyrna for more than eight years service on the authority board from which he was resigning.

Tenth District

New president-elect of the Georgia Heart Association is **Robert G. Ellison**, chief of the Division of Thoracic Surgery at the Medical College of Georgia in Augusta. Dr. Ellison was selected at the Association's Silver Anniversary meeting September 21.

Former MCG faculty member **Louis A. Wilson**, has been appointed associate professor of ophthalmology at Emory Clinic and Grady Memorial Hospital and will direct the residency program for the Department of Ophthalmology.

Armand B. Glassman, Augusta, presented a lecture on sickle hemoglobin at the scientific meeting of the South Carolina Society of Medical Technology.

Edwin S. Bronstein presented a paper to the annual meeting of the American College of Obstetricians and Gynecologists and has received a grant from the Georgia Department of Human Resources for the continuation of the Georgia Regional Laparoscopic Sterilization Program.

Paul D. Webster recently participated in an NIH and American Digestive Disease Society conference, and has received a grant from the National Institute of Arthritis, Metabolic and Digestive Diseases for study of "Control of Pancreatic Protein Synthesis and Secretion."

During the AMA meeting, **Malcolm N. Luxenberg** presented a paper at the section of ophthalmology. He has also received a grant from Fight for Sight, Inc.

John R. Palmer, of the MCG faculty, has received a grant from the Bureau of Health Manpower Education for the Physician's Assistant Program.

The Georgia Heart Association has presented **James**

B. Hudson with a grant for a "Chair of Cardiovascular Research." Another MCG faculty member, **Alex F. Robertson**, has been given a study grant from G. D. Searle and Co.

DEATHS

Edward Gonzalez

Edward Gonzalez, 38, of Rome died September 14 in Birmingham, Ala. following heart surgery performed as a result of an earlier massive coronary.

Dr. Gonzalez was born and educated in Bogota, Colombia, studied at Javeriana Medical School and Henry Ford Hospital in Detroit, Mich. He was a member of the American College of Gynecology and Obstetrics as well as the local, state and national medical associations.

Survivors include his widow, Karen Keolling Gonzalez; son, Edward Gonzalez, Jr.; two daughters, Pamilla and Ana Patricia Gonzalez of Rome; mother, Mrs. Marie Ester Gonzalez; and sister, Mrs. Anita Leiva of Bogota, Colombia.

Eugene L. Griffin

Obstetrician and gynecologist Eugene L. Griffin, 61, died suddenly of a heart attack at his home in Atlanta September 2.

Dr. Griffin served as chairman of the MAG Committee on Maternal and Infant Welfare and was a member of the American College of Obstetricians and Gynecologists, AMA, Medical Association of Atlanta, Capital City Club and the Cathedral of St. Philip. He served as a member of the Governor's Special Council on Family Planning.

A 1936 graduate of Emory School of Medicine, Dr. Griffin interned at Grady Memorial Hospital and was a resident at the New York Lying-In Hospital in New York City. While serving with the U.S. Army Air Corps during World War II, he was awarded the Silver Star.

Survivors include his widow, the former Joan Miller; sons, Ralph D. Griffin and Steven L. Griffin of Atlanta.

HEART ASSOCIATION HAS NEW LEADERSHIP

A new slate of officers and directors of the Georgia Heart Association was named at the September 21 Silver Anniversary Annual Meeting of the Association in Atlanta.

Named as president-elect was **Robert G. Ellison**, of the Medical College of Georgia. Atlanta surgeon **Charles R. Hatcher, Jr.** took office as president and **George E. Smith** was elected to his third term as board chairman.

Myer O. Sigal of Macon was re-elected vice-president

and **C. Dan Cabaniss** of Columbus as second vice-president. **Joe T. LaBoon** and **Kirk M. McAlphin** of Atlanta were re-elected as secretary and treasurer.

Ten new directors include: **Walter J. Brown, Jr.**, Athens; **Lloyd Burrell**, Savannah; **Clifford S. Campbell, Jr.**, Thomasville; **Huddie L. Cheney**, Thomasville; **J. Philip Cleveland**, LaGrange; **William B. Fackler, Jr.**, LaGrange; **Walter L. Purcell**, Decatur; **Nanette K. Wenger**, Atlanta; **J. Robert White**, Dublin; and **Thomas J. Yeh** of Savannah.

CONTINUING EDUCATION COURSES IN GEORGIA

As a service to MAG physicians who wish to maintain their competence and skill by participating in continuing education programs, the following list of courses for 1973 and 1974 is published. The courses below are sponsored by organizations accredited for continuing medical education by the Council on Medical Education of the American Medical Association.

These Georgia courses have been taken from the Supplement to *The Journal of the American Medical Association*, Volume 225, Number 7, which lists similar programs for 48 states and the District of Columbia.

The courses are listed in chronological order and most references contain, in the following general order: the title of the course; name and address of the sponsoring organization; location; dates; number of hours of instruction; fee, if any; and the methods of instruction used. Space considerations have prompted the use of the following abbreviations for these methods of instruction:

Methods:

AV—Audiovisual aids
CLIN C—Clinical conference
LAB—Laboratory work
LEC—Lecture
O—Open question periods
OP—Enrollee observes procedure
PAN—Panel discussion
PI—Programmed instruction
PP—Enrollee performs procedure
SEM—Seminar
TV—Television

OCTOBER

BASIC LAB METHODS IN THE DETECTION OF HEMOGLOBINOPATHIES

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
4 days, 10/15/73 to 10/18/73 and 3/11/74 to 3/14/74; 28 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

TUBERCULOSIS TODAY!

Center for Disease Control, Tuberculosis Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 10/15/73 to 10/19/73; no fee
Methods: AV, CLIN C, OP, PP, O, PI, SEM

CANCER: CLINICAL MANAGEMENT

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
1 day, 10/19/73; 6½ hours of instruction
Methods: AV, LEC, O, PAN, SEM

PHYSICIANS' CONTINUING EDUCATION SERIES

Laurens County Medical Society and V.A. Center, Dublin
Held at the V.A. Center and Brown's Restaurant, Dublin
4 hours/day, 1 day/month for 5 months, 10/23/73, 11/27/73, 1/22/74, 2/26/74 and 3/26/74; 20 hours of instruction
Methods: AV, LEC, O

CURRENT CONCEPTS OF CARDIOVASCULAR DISEASE

Muscogee County and Third District Medical Societies
Contact: Simone Brocato, M.D., Physicians Building, Columbus 31901
St. Francis Hospital, Columbus
1 day, 10/25/73

BASIC LABORATORY METHODS IN VIROLOGY

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 10/29/73 to 11/9/73 and 3/18/74 to 3/29/74;
70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

DECISION MAKING IN INTERNAL MEDICINE

American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104
At the Medical College of Georgia, Augusta 30902
5 days, 10/29/73 to 11/2/73; 32½ hours of instruction
Methods: AV, LEC, O, PAN, SEM

LABORATORY METHODS IN ANAEROBIC BACTERIOLOGY

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 10/29/73 to 11/9/73; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

NOVEMBER

FAMILY PLANNING

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
2 days, 11/1/73 to 11/2/73; 13 hours of instruction
Methods: AV, LEC, O, PAN

CLINICAL MICROBIOLOGY IN CONTROL OF NOSOCOMIAL INFECTIONS

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 11/12/73 to 11/16/73; 35 hours of instruction
Methods: AV, OP, LEC, O

HUMAN BLOOD CELL MORPHOLOGY

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 11/12/73 to 11/16/73; 35 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

MALARIA: LAB DIAGNOSIS

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 11/12/73 to 11/16/73; 35 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

WORKSHOP ON TECHNIQUES OF RESPIRATORY THERAPY

American Society of Anesthesiologists
515 Busse Highway, Park Ridge, Ill. 60068
At the Hyatt Regency Atlanta, 265 Peachtree Street, N.E., Atlanta 30303
2 days, 11/17/73 to 11/18/73; 16 hours of instruction
Fee: \$75 for members; \$100 for non-members
Methods: AV, LEC, O, PAN

PRINCIPLES AND BACTERIAL APPLICATION OF FLUORESCENT ANTIBODY TECHNIQUES

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 11/26/73 to 12/7/73; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

JANUARY

PHYSICIANS' CONTINUING EDUCATION SERIES

Whitfield County Medical Society, Dalton and the Medical College of Georgia
At Hamilton Memorial Hospital, Dalton
4 hours/day, 1 day/month, 1/74 to 4/74; 16 hours of instruction
Methods: AV, LEC, O, PAN, SEM, TV

LAB DIAGNOSIS BY SEROLOGIC METHODS

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 1/7/74 to 1/18/74; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

LAB METHODS IN MEDICAL MYCOBACTERIOLOGY

Center for Disease Control, Lab. Div., USPHS
10 days, 1/7/74 to 1/18/74; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

CLINICAL PSYCHIATRY

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
2 days, 1/24/74 to 1/25/74; 13 hours of instruction
Fee: \$60
Methods: AV, LEC, O, PAN, SEM, TV

DETECTION OF SALMONELLA IN FOODS AND FEEDS BY FLUORESCENT ANTIBODY AND CULTURAL METHODS

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 1/28/74 to 2/8/74; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

FEBRUARY

LAB DIAGNOSIS OF VIRAL DISEASE

Center for Disease Control, Lab. Div., USPHS

1600 Clifton Road, N.E., Atlanta 30333
10 days, 2/4/74 to 2/15/74; 19½ hours of instruction
Methods: AV, LEC, O, PAN, SEM, TV

MEDICINE AND RELIGION

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
1 day, 2/7/74; 6½ hours of instruction; Fee: \$10
Methods: AV, LEC, O, PAN, SEM

NEUROLOGY IN ADULTS AND IN CHILDREN

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
2 days, 2/14/74 to 2/15/74; 13 hours of instruction
Fee: \$70
Methods: AV, LEC, O, PAN, SEM, TV

LAB METHODS IN GENERAL MEDICAL BACTERIOLOGY

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 2/18/74 to 3/1/74; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

MARCH

QUALITATION AND QUANTITATION OF IMMUNOGLOBULINS

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 3/4/74 to 3/8/74; 35 hours of instruction

LAB METHODS IN ENTERIC BACTERIOLOGY

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 3/18/74 to 3/29/74; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

MANAGEMENT OF GERIATRIC PROBLEMS IN FAMILY PRACTICE

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
2½ days, 3/21/74 to 3/23/74; 17 hours of instruction
Methods: AV, LEC, O, PAN, SEM, TV

BIOMATERIALS FOR ORTHOPAEDIC SURGEONS

American Academy of Orthopaedic Surgeons
430 N. Michigan Avenue, Chicago, Ill. 60611
At the Marriott Motor Hotel, Atlanta
1 day, 3/30/74; Fee: \$40 M.D.s, \$20 residents
Methods: AV, LEC, O, PAN

APRIL

LAB METHODS IN DERMATOLOGIC MYCOLOGY

Center for Disease Control, Lab. Div., USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 4/1/74 to 4/12/74; 70 hours of instruction
Methods: AV, OP, PP, LAB, LEC, O

GASTROENTEROLOGY

Medical College of Georgia School of Medicine
1459 Gwinnett Street, Augusta 30902
2 days, 4/4/74 to 4/5/74; 13 hours of instruction
Fee: \$70
Methods: AV, LEC, O, PAN, SEM

LABORATORY METHODS IN PARASITOLOGY

(Part I: Intestinal Parasites)

Center for Disease Control, Lab. Div., USPHS

1600 Clifton Road, N.E., Atlanta 30333

20 days, 4/8/74 to 5/3/74; 140 hours of instruction

Methods: AV, OP, PP, LAB, LEC, O

MAY

LAB METHODS IN MEDICAL PARASITOLOGY

(Part II: Blood Parasites)

Center for Disease Control, Lab. Div., USPHS

1600 Clifton Road, N.E., Atlanta 30333

10 days, 5/6/74 to 5/17/74; 70 hours of instruction

Methods: AV, OP, PP, LAB, LEC, O

THE TREATMENT OF CORONARY SYNDROMES

American College of Cardiology

9650 Rockville Pike, Bethesda, Md. 20014

At the Royal Coach Motor Hotel, Atlanta

3 days, 5/6/74 to 5/8/74; 24 hours of instruction

Fee: \$130 members, \$180 non-members

Methods: AV, LEC, O, PAN, SEM, TV

SPORTS MEDICINE

American Academy of Orthopaedic Surgeons

430 N. Michigan Avenue, Chicago, Ill. 60611

At the Holiday Inn, Callaway Gardens, Pine Mountain

5 days, 5/12/74 to 5/16/74; Fee: \$150 M.D.s, \$50 residents

Methods: AV, LEC, O, PAN

BASIC LAB TECHNIQUES IN CELL CULTURE

Center for Disease Control, Lab. Div., USPHS

1600 Clifton Road, N.E., Atlanta 30333

6 days, 5/17/74 to 5/24/74; 42 hours of instruction

Methods: AV, OP, PP, LAB, LEC, O

ADVANCED TECHNIQUES IN THE LAB DETECTION OF ABNORMAL HEMOGLOBINS

Center for Disease Control, Lab. Div., USPHS

1600 Clifton Road, N.E., Atlanta 30333

5 days, 5/20/74 to 5/24/74; 35 hours of instruction

Methods: AV, OP, PP, LAB, LEC, O

JUNE

INTERNAL MEDICINE

Medical College of Georgia School of Medicine

1459 Gwinnett Street, Augusta 30902

At the Savannah Inn and Country Club, Savannah

3 days, 6/20/74 to 6/22/74; 12 hours of instruction

Fee: \$100

Methods: AV, LEC, O, PAN, SEM, TV

JULY

LAB METHODS IN GENERAL MEDICAL MYCOLOGY

Center for Disease Control, Lab. Div., USPHS

1600 Clifton Road, N.E., Atlanta 30333

20 days, 7/74; 140 hours of instruction

Methods: AV, OP, PP, LAB, LEC, O

CARDIOLOGY AND THE PROBLEM-ORIENTED SYSTEM: A PRECEPTORSHIP IN THE PRACTICAL USE OF THE SYSTEM

American College of Cardiology

9650 Rockville Pike, Bethesda, Md. 20014

At Grady Memorial Hospital, 80 Butler Street, S.E., Atlanta

Dates to be arranged

Fee: \$100 members and non-members

Methods: AV, BR, LEC, O, TV

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THE MONTH IN WASHINGTON

Legislation providing federal aid for establishment of a limited number of experimental Health Maintenance Organizations (HMO's) bills advanced in Congress. The House bill was much smaller in scale (five years, \$240 million, compared to \$805 million) than one passed the Senate.

In a report on the HMO bill, the House Commerce Committee discussed HMO's and their possible future role in health delivery. No specific number limitation was set in the House bill, but "it is anticipated that the limit of authorizations to \$240 million and the reality of the budget and appropriation process will provide an effective ceiling on the number of HMO's which could be established. . . . Generally, however, the committee would anticipate that this legislation would be used to bring to the operating stage approximately 100 new HMO's."

The report stressed a five-year cut off. "All federal assistance to all assisted HMO's will be completed by the end of five years for which authority is given. Thus, there will be no need to extend or renew this legislation in order to meet outstanding commitments."

After a discussion of "many arguments in favor of HMO's," the report said the committee "is concerned about the fact that HMO's (pre-paid group practice, contract practice, etc.) have not grown more rapidly than has been the case." The committee said it hoped the HMO program would clarify many problem areas, including such basic questions as "will federal assistance to HMO's work?" Other matters of concern were listed as whether federally-aided HMO's will be able to survive without federal help; how well will such organizations serve the poor, chronically ill, and aged; how will they work in ghettos, rural areas; what about consumer acceptability, quality of services, etc.

Noting that an HMO operates under an income limit (the premiums paid), the committee said one fear is that "it would be possible for an HMO to respond to this limit by discouraging the utilization of its services. For example, the committee is concerned with the possibility that elective surgery such as cataract extractions in elderly people, might be delayed in situations where an HMO is experiencing higher than expected utilization. These practices are to be discouraged."

Cautioning against allowing an HMO to have a monopoly anywhere. The Committee said:

"The heterogeneity of the HMO's envisioned by the committee is the key characteristic of the HMO program authorized by this legislation and deserves particular comment.

"In preparing the legislation, the committee has attempted not to described exhaustively or in detail a single 'proper' system for the delivery of health services. The legislation defines desirable qualities of any system for health care delivery and offers to support any HMO which includes these qualities, however, it may be structured or organized in detail. *Thus, the HMO program sponsored by this legislation would not represent a single*

monolithic or federally-controlled health system, but a series of additions to our existing pluralistic system."

The Committee said that one reason there are few HMO-type programs operating now "is the high cost of planning, development, and initial operations. It has been estimated that the group practice model requires as many as 30,000 enrollees before the plan breaks even with as much premium income as expenses. Planning costs for this type of HMO can go up to a half million dollars. Operating deficits until the break-even point can amount to \$2-3 million."

Unlike the Senate bill, the House legislation does not pre-empt state laws that restrict formation of HMO's. The reason given by the House Commerce Committee was "the rapid change already underway in state legislation designed to remove these barriers . . . (with) . . . approximately 20 states have already adopted legislation specifically authorizing HMO's."

Retirement Savings Restriction

The outlook in Congress for a new restriction on retirement savings of professional service corporations and a companion liberalization of the Keogh plan for the self-employed was cloudy. Opposition to the limitation on the professional service corporations was reported strong in the House, though the Senate was expected to approve it.

The Senate Finance Committee said in its report on the bill that "it is contended that the present law in the retirement plan area creates an artificial incentive for the incorporation of businesses which more traditionally, and perhaps more appropriately, have been conducted in unincorporated form."

The committee restricted the amount an incorporated professional could save for retirement purposes and receive federal income tax deferred on to \$7,500 a year and not more than 15 per cent of income. The Keogh plan was liberalized to the same levels.

Noting that in recent years all states have adopted special incorporation laws which allow professional corporations, the committee said these "have been used increasingly by groups of professional persons, primarily to obtain the more favorable tax treatment for pensions generally available to corporate employees." The Internal Revenue Service's adamant opposition to these corporations and refusal to recognize them in the so-called Kintner regulations was rejected by the courts until "the service has now acquiesced and generally recognized these professional corporations as corporations for income tax purposes."

The committee said "the formation of professional corporations, a practice which has proliferated enormously in recent years, has had the effect of circumventing the limitations which Congress intended to impose on deductible contributions by persons who are essentially, in most respects, self-employed."

Explaining why it didn't impose any limit on regular

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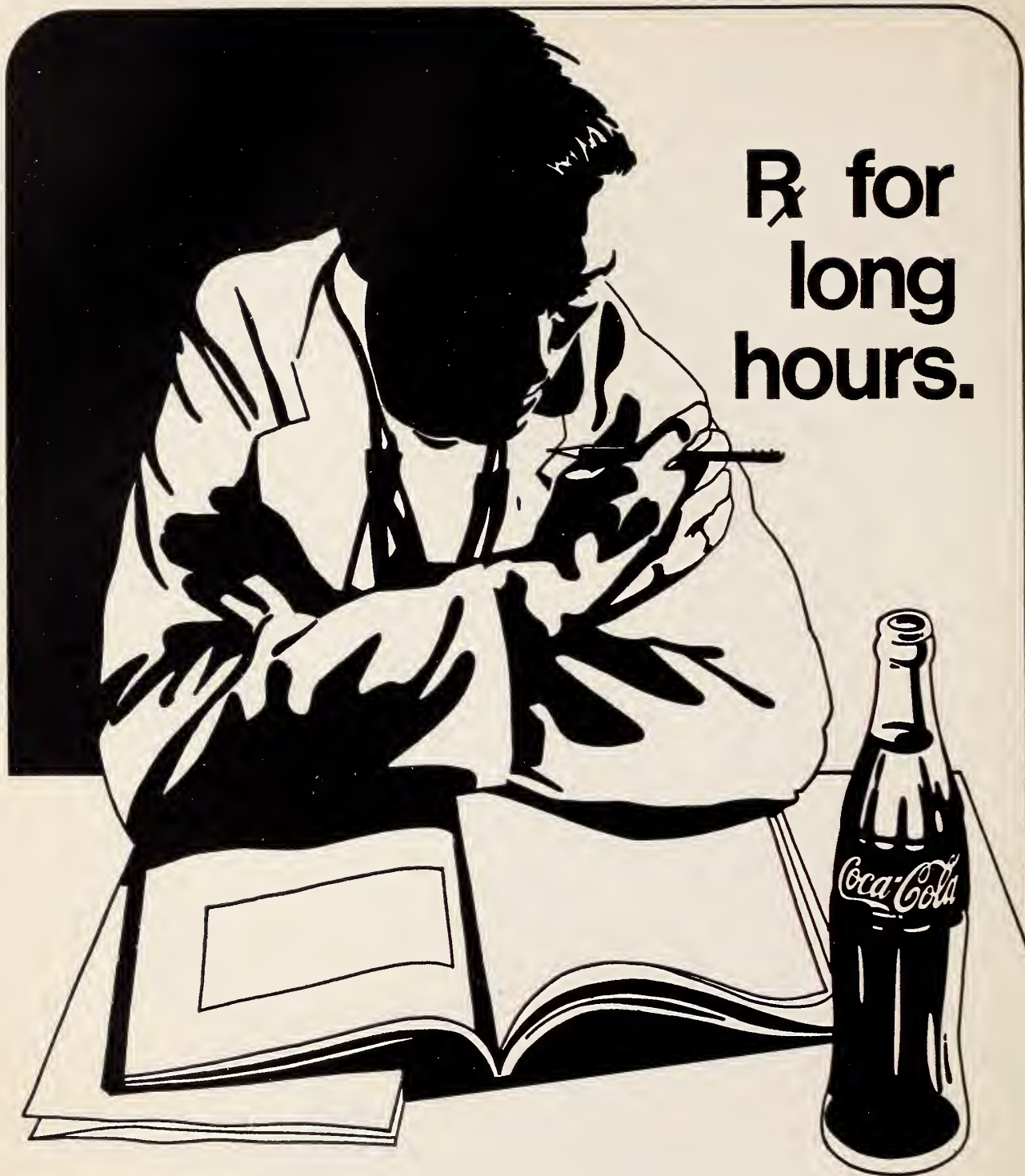
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corporation tax deferrals for high-salaried executives, the committee said that in corporate plans a "much larger percentage of the contributions and benefits go to the 'rank and file' employees." This "financial drag effect tends to impose practical restrictions. . . ."

Librium, Valium Action

Librium and Valium will be subject to tighter federal restrictions. Under a Justice Department proposal, which has been accepted by the manufacturer, Roche Laboratories, the two tranquilizers will be placed in category IV of the Controlled Substances Act. Other major tranquilizers already are in this category.

A prescription may be refilled no more than five times and a written prescription would be valid for no longer than six months. A renewal of the prescription after these limits would require a written prescription.

The proposal would place additional record-keeping and other requirements on drug manufacturers and pharmacists. Primary aim is to prevent diversion into illicit channels.

Cough-Cold Drug Action Delayed

The Food and Drug Administration agreed to delay action against prescription cough, cold and allergy products. Interim guidelines will not be implemented until the FDA's over-the-counter review panel has issued a monograph, not expected until next year. Controversial guidelines issued last spring would have prohibited the use of combination antitussives and/or expectorants or decongestants for the common cold and the use of antitussives combined with antihistamines and decongestants for allergic or vasomotor rhinitis. Pharmaceutical and medical groups protested then the lack of input from the medical profession on the proposed ban. Witnesses urged that action be postponed until the scientific community can review the OTC panel's report which is slated to cover much the same ground.

GP Bill

The Administration is planning to appeal a District Court Judge's ruling that President Nixon's pocket veto in 1970 of legislation to aid training in the practice of family medicine was unconstitutional.

The veto of the \$225 million bill to help hospitals and medical schools set up family medicine departments came during a Christmas recess of Congress. The President claimed he killed the bill by use of the "pocket veto" by refusing to sign the bill while Congress was out of town. Sen. Edward Kennedy (D., Mass.) who filed suit against the President, contended that it was an improper use of the "pocket veto." Actually, he said, the bill became law because the President did not veto it in the normal way thus giving Congress the chance to override it.

The Constitution gives the President 10 days in which to sign or veto a bill passed by Congress. If he does neither and Congress is in session the bill automatically becomes law. If Congress is in adjournment, the bill dies.

U.S. District Court Judge Joseph Waddy in Washington, D.C., held that the recess in question did not constitute an adjournment. The Judge gave the Administration until September 9 to comply with his order.

Administration's Health Goals

HEW Secretary Caspar Weinberger said that health care improvements will come from building "on our historic existing strengths" rather than "tearing down the entire structure because of our dissatisfactions."

In an address to the American Health Congress in Chicago, the Secretary said his Department was "absolutely and totally committed to do whatever may be necessary to assure that quality health care is readily and equally available to every American."

He said, however, that meeting this goal means devising "a total health strategy in which every possible program or option is carefully and objectively weighted—against each other and against the limits of our present revenue resources—before decisions are made."

"No longer are we committed to support all on-going programs," said the Secretary, "just because we once decided to start them."

"We have made the basic decision to build on our historic strengths in the health care field," he said, "closing obvious gaps, making needed improvements and instituting prudent innovations—rather than tearing down the entire structure because of our dissatisfactions and starting on something entirely different."

He said the nation would not stand by while inner city residents lack decent health care, 120 American counties are without medical facilities and health personnel, costs skyrocket past the means of average citizens, and "the dangerous trend toward overspecialization in medical practice," continues.

"This Administration is prepared to pay the bill for an improved health care system," said Secretary Weinberger, "but only for concrete results."

He said that means "that while we're raising the Federal investment in health care—we are also reducing the unrealistic expectations of some program managers. We are also determined to make each Federal dollar stretch further."

He noted that for the current fiscal year, "the President has proposed a 21 percent increase in health funding. That amounts to nearly \$4 billion more—and brings the total Federal health investment to nearly twice the annual amount spent when President Nixon took office."

He said the Administration's "total health strategy involves a number of new initiatives and a conscious attempt to weave together existing programs which meet well-defined needs and new approaches which not only fill present gaps, but will meet estimated future needs."

He said the four highest priorities are:

National Health Insurance; Health Care Cost Control; the National Cancer and Heart Programs, and movement toward an all volunteer blood supply.

VA Bill Into Law

Legislation signed into law by President Nixon extends Veterans Administration medical care to certain dependents, assures peacetime veterans the right to VA medical care and streamline VA rules on health care delivery.

Outpatient medical care for non-service connected conditions is authorized when it would avoid the need for hospitalization.

The law, effective September 1:

- Extends eligibility for medical care to the wife or child of a person who has a total and permanent disability, resulting from a service-connected condition,

and to the widow or child of a person who has died of a service-connected condition. Care will be provided in a manner similar to that in which medical care is furnished by the Armed Forces under the so-called "CHAMPUS program" to dependents and survivors of active duty and retired personnel.

- Removes the requirement for wartime service as a condition of eligibility for VA medical care.

- Liberalizes rules on providing VA outpatient or ambulatory care any veteran who is now eligible for VA hospitalization can be treated as an outpatient as necessary to preclude the need for hospital admission.

- Authorizes direct admission to nursing homes, at VA expense, of veterans requiring nursing home care for service-connected disabilities as stated by a VA physician.

- Specifically authorizes VA outpatient care for all disabilities for veterans with service-connected disabilities rated 80 percent or more disabling.

- Provides for the National Academy of Sciences to study the staffing of the VA hospitals and report on this subject.

- Extends VA mental health service to the families of veterans when it is related to the mental health or rehabilitation of an eligible veteran.

CHECK ON METHADONE REGULATIONS

Federal regulations which became effective March 15, 1973 require prior approval before hospitals and physicians may prescribe or administer methadone to treat narcotic addiction or severe pain.

If you would like information or technical assistance concerning these new regulations, or the treatment of drug abuse and addiction, contact the following office by mail or telephone: Drug Abuse Services Section, Attn: James E. Delaney, Suite 901, 615 Peachtree Street, N.E., Atlanta, Georgia 30308. Phone: (404) 656-2748.

EMORY RECEIVES CAPITATION GRANTS

The U. S. Department of Health, Education, and Welfare has awarded capitation grants totaling more than \$1,400,000 to the schools of medicine and dentistry at Emory University.

Capitation grants were allocated on formula basis to health professions schools to provide support for educational programs and to increase enrollments.

The grants were authorized by the Comprehensive Health Manpower Training Act of 1971 and awarded by the Bureau of Health Resources Development of the new Health Resources Administration of HEW. Emory's medical school was awarded a capitation grant of \$762,486 for the current fiscal year, and the Emory dental school received \$666,691 according to the HEW announcement.

Both schools at Emory will enroll their largest freshman classes ever this fall, with estimated new enrollment in medicine 258 and in dentistry 105. Estimated new medical school enrollment includes 104 new medical students and 154 new allied health students.

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Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	½
50	0.5	1
75	0.75	1½
100	1.0	2
125	1.25	2½
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days. This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

**JOURNAL
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Cover

The doctor as delegate is portrayed on November's cover calling attention to the important Special Session of the House of Delegates in December at Atlanta's Marriott Motor Hotel. For details, please read the President's Letter and the Official Call which follows it. Design by artist Bob Hamill.

***Instead of "letting the government do it,"
physicians must take the first step with
personal concern and involvement in
the people of the world who need
their care.***

Before the First Shot

JAMES W. TURPIN, M.D., San Diego, California*

IT WAS WITH SOME PERSONAL satisfaction that I chose the title, *Before the First Shot*, for this Annual session. Speaking to fellow physicians, I could imagine the variety of interpretations of such a title: *Before the First Shot*.

1. The serious questioning of a patient about drug sensitivities or allergies before giving an injection;
2. Some appropriate self-questioning before one downs a first ounce of Southern Comfort—straight;
3. The all important "waggle" before teeing off at hole one;
4. Or, perhaps, as is intended, the serious contemplation of our present dilemma before someone fires the first violent and explosive missile of World War III.

Haves vs. Have Nots

The next, greatest and possibly last world conflagration will not be contested between East and West, not even between the collectivists and capitalists; no, not even between male and female or parents and teenagers. The very real probability is that the next "war to end all wars" will be fought between the "haves" and the "have nots."

The lines will be drawn not by color, national origin, creed or economic philosophy. Hungry people, poor and illiterate people, sick and disillusioned millions all over the world will unite to form an awesome horde of enthusiastic, patriotic and deadly determined zealots bent on seeing revolutionary changes of whatever nature brought about by the devastating destruction of the status quo.

There should be no mistake that this rebellion, the "revolution of rising expectations," is already under-

way. Neither should anyone question that we, as members of organized medicine, are a well identified and targeted part of that discredited "status quo."

If ever poor people really didn't mind their poverty, that day is long since passed. Estes Newberry, a worn out coal miner, watches Marcus Welby, M.D. on a dilapidated black and white television set in remote Hanging Limb, Tenn. He sees the well staffed, modern hospital with all of its fascinating equipment, and wonders why he must be denied the sophisticated inhalation therapy that promises some easing of his gasping, panting hell of pneumoconiosis.

There is a popular credo among the more eager defenders of the status quo which says briefly and simply "Let the government do it." These are the same protectors of "now and as is" who object to still higher taxes, who question the real value of vast, comprehensive government sponsored and financed health service delivery systems, the very same devotees of: "I've made it so why don't you work to make yours," who offer no valid, workable, attractive, and saleable alternative.

Personal Participation

This presentation seeks to define a very real and very present problem. It hopes to dispel some erroneous popular concepts of the nature of the poor and sick. I want to illustrate the inadequacy and inappropriateness of still larger government intervention in health care, even as we see the foolishness of doing nothing. I then would present a case for our personal participation in an ambitious and promising program of private, charitable, non-governmental medical care. I believe the answer to our medical dilemma is the private physician and organized medicine and care. I believe it is our professional birth-

* Founder and international director of Project Concern, a non-profit medical and dental assistance program. Dr. Turpin spoke at the 119th Annual Session of the Medical Association of Georgia, May 10-13, 1973 in Augusta, Georgia. Photographs have been supplied by Project Concern's headquarters in San Diego.

right to *voluntarily* assume the opportunities of caring for *all* the people in *all* of the places. I want earnestly to see private medicine identify itself with the sick and disadvantaged. I dream of, and work for, a time when the followers of Hippocrates will become the diviners of *all* human life.

It is perhaps too easy to believe that there is no problem—and even if there is, to consider that the physician is not the answer. Some of you may feel such pressure is inappropriate, that private practitioners are unfairly treated, maligned for problems they did not create and cannot or should not solve. In his *Devil's Dictionary*, Ambrose Bierce defines a physician as “one upon whom we set our hopes when *ill*, and our dogs when well.”

This probably applies more to the total American medical system than to individual physicians today. But we are defensive, even testy about the criticisms of our profession, our practice and our organizations. Our medical skills, facilities and equipment, where available, are the best in the world. Costs, as compared with other professions and institutions, are reasonable, often operating at a loss, frequently treating the indigent without any consideration of payment. (What physician here does not have a file full of accounts receivable with a large percentage tagged “uncollectible”?)

But it is not what we are doing that I have come to discuss. Our reward for that is personal and professional satisfaction—and, generally, adequate remuneration. I have come to alert you that there are millions of persons in thousands of places where a squalored, dignity-sapping existence erodes the bodies and minds of those who have forgotten what it is to hope.

I have helped bury pot-bellied Montagnard children in the Central Highlands of South Vietnam, young promises who have succumbed to Kwashiorkor's. I have attempted treatment of Pott's disease for emaciated, grotesquely deformed Mexican children whose blood-expectorating mothers and fathers do not appreciate the presence of “red bugs” in the wetness of a kiss. I have flashed a bright light into the unseeing blackness of young eyes obliterated by trachoma, never having the opportunity of “seeing” the miracle of ophthalmic antibiotic ointment. And the seething disenchantment grows. . . .

Case of the Trapped

A case history—a case in point: In Canderleria, Colombia, Francia's life centers on money, or rather, the lack of it. Raul earns 500 pesos a month cutting sugar cane; it goes for food for the six of them plus a little for tobacco, a little for kerosene, occasionally



SERVING SOUTHEAST ASIA

Project Concern's Dr. Gene Griffith attends a small Montagnard boy suffering from protein deficiency. Dr. Griffith directs the project's two hospitals in the Central Highlands and supervises a paramedic training program which teaches young villagers to administer primary medical assistance, initiate good sanitation practice and establish public health education programs in the hamlets.

some soap. She looks at the few things on the scarred table that is jammed among the mats. She has grown used to a single simple equation, money spent for soap or chocolate, or anything else, means either the bone or the potatoes go out of the soup for tonight.

It is easier without Juanito. The baby hadn't eaten much, but his was another mouth. And food was only part of the problem. The medicines cost so much. To buy all they told her to buy would have meant no food at all.

What mood would Raul be in tonight? No mood, she hopes. Last night she could tell from the way he watched her. As soon as she sensed it, she was taken by a sense of panic. She avoided looking at him, hardly spoke to him, was careful not to go near him, even brush against him. When the meal was over, she mumbled that little Inez was sick and she slept with her. Then she lay awake, fearing he would come to her anyway, wondering what she could do if he did.

She had been wrong. Life is more than money and food. It is money and food *and* avoiding Raul. She had tried everything; ignoring him, staying dirty, pushing him away, utter passivity (above all else,

don't reach a climax—that is the surest way to pregnancy and the surest way to bring Raul back again).

In the night, she hears him move on the newspapers that cover the hard mats, and then he goes out. He is going up the street for his satisfaction. She is relieved. He won't want her for a few more nights. Then her period will come and she will be all right for a few more nights.

The chilling thought (it comes so often); what will happen if Raul leaves her? Tired of the soup, tired of the crowded shack, tired of her fending him off, tired of the steel trap that is their existence—how can he stay? They have long since stopped talking about life and what they might do with it, about the children and what could be hoped for. Mario was the first child, then Pablo, then Isabel, then slowly in their semi-illiterate way, they became aware of the awful arithmetic of pesos and people: 500 pesos isn't enough for six people. The thought of the number reaching seven again is shattering. Juanito had shown them that. She and Raul agreed there would be no more children after Inez, and they fought against it in every way they knew. There are many things to do and use, but none are very certain—not certain at all—for she got pregnant three more times. Twice the old lady took care of it with the long rubber tube (20 pesos for every month of pregnancy) but the second time was very bad. Something went wrong; pain, fever, shaking, and two weeks in the hospital. That was why she let the third one, Juanito, go all the way.

He wasn't a strong baby. Cried a lot. Had diarrhea. Didn't nurse well. It was inevitable that he should die. It was almost so when she left him at the hospital. It was nearly a month later when they sent for her—to give her the death certificate she supposed. Instead, they gave her Juanito. He was bundled in a clean blanket, sleeping, content. He seemed quite well. She was surprised, confused, puzzled. And the young doctor who handed him to her was angry for some reason.

He glared at her, "You don't care, do you?" She didn't understand why he said that, but she knew he didn't understand her. He wore gold cufflinks and had a pretty monogram on his shirt. Juanito cried as she took him from the hospital. He cried at home, too, until he died.

But some might say "Why don't they help themselves? If they weren't so lazy they'd have better care. They just don't care."

Impossible Arithmetic

Evaluate the problem for a moment. World health experts use the Gross National Product as a guide to a nation's economic ability. According to the World Bank, in 1965 the United States produced

\$3,240 per capita. Of that, \$200 per capita was spent on medical care. At least half of the countries of the world produce less in total goods and services per capita than we spend on medical care alone. Ethiopia produces approximately \$50 per capita. India produces \$100. In other words, if India neglected food, clothing, housing, education and defense entirely—there would still be no hope of reaching the level of medical care in the United States.

But some will reason that these are hardly our problems, that we should clean up our own back yard first. It is a human litter-strewn "back yard" with the weeds of unconcern and indifference choking what hope might otherwise exist. What of our own back yard?

Closer to Home

Elizabeth Murphy is dead. She had repeated sore throats as a small, three-year-old child, saw a local medical doctor 12 miles from home one time only, had one shot of penicillin. The impoverished mountain parents of seven could not bring themselves to face the indignity of a still larger medical bill—and so refused to take her back despite fever after fever.



TREATMENT IN ETHIOPIA

A team of medical professionals administer aid to a small patient in Project Concern's 107-bed hospital in Keren, Ethiopia, which with seven health stations in outlying areas promises hope of better health care for 125,000 nomadic tribesmen. Paramedics are being trained here to aid the mere 365 medical professionals in a country of 27 million people.

Those damnable streptococcal-induced growths continued undetected on her cardiac valves—no physician, no strep titers, no bicillin. One day, age 12, playing innocently at school, a warty portion of that valvular growth tore loose, occluding her coronary artery—and Elizabeth Murphy was dead before her slender, pale body crumpled into the dirt of that dilapidated Appalachian school.

There is hardly a clinic day which passes in my present work in a four county area of Tennessee (known as the Upper Cumberland Plateau) in which I do not encounter at least one or two patients for whom I must make some medical or surgical compromise:

1. Millie Lou Bilbrey must wait to go to the county's only hospital until she is fully dilated and so very near delivery that the emergency room personnel cannot possibly refuse her admission (and her husband makes 75 cents per 1,000 chickens caught and crated during a frenzied, exhausting all-night work shift).

2. Abi Phillips, an elderly widower with a marked refractory error stumbles through his blurred, despondent aloneness because his \$72 a month social security marginal existence does not allow for a \$45 pair of corrective lenses;

3. Josh Stannick was born with a huge hemangioma of his face and neck. Mucus drooled from his thickened, beefy-red incompetent lips until one surgery three years ago gave him moderate control of his saliva. Since then, the local state rehabilitation office has told him repeatedly, "Sorry, there is no more money for any more surgery." And this alert 25-year-old mountain youth daily becomes more withdrawn, suspicious, alone and discouraged.

These are but a few. Almost identical cases can be found in every county of Tennessee—and my native state of Kentucky. I suppose Georgia is not markedly different. I will not be guilty of remotely suggesting that these unfortunate cases are the majority—as my friend Sen. Edward Kennedy would have us believe. Neither do I propose that we have achieved a medical utopia where there are no physician, institutional bed, clinical, or pharmaceutical shortages. What we do have for whom we have it, is the best in the world.

But today, *all* of the people will be served. The word is out. Modern American medicine is more in demand than cable television. Until we extend our coverage to every home in America, and some day, throughout the world, we will continue to have bizarre answers promulgated by non-professional "experts" who feed politically on the nutritious vacuum of limited care we allow, by our own unconcern, to plague the lives of our people.

For several generations now our country has been experiencing a most interesting phenomenon. Institutions are surrendering to the state and federal governments increasing amounts of responsibility for those services which formerly were provided by the private sector.

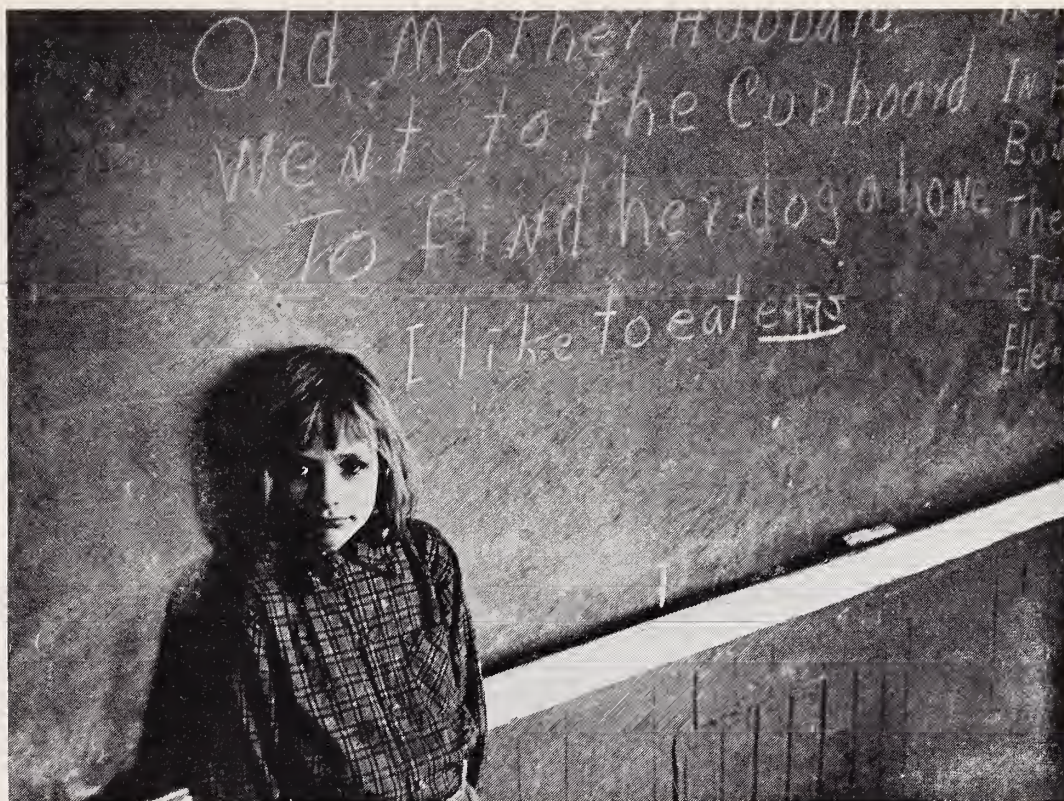
Briefly, the Protestant churches are a good example. (I omit the Roman Catholic Church for I am a Protestant—and because I suspect the Romans have done a better job than my church.) There was a time when the churches built schools (Emory, Duke, Baylor, etc.), hospitals (Georgia Baptist, Methodist in Houston, Presbyterian, etc.), orphanages, retirement facilities, etc. Interest in and support for missions has decreased to such a low point that foreign and domestic medical, educational and agricultural activities have been eliminated or seriously curtailed. Memberships are down generally, contributions dwindling, attendance discouraging. And the schools are now largely state schools, the hospitals are private corporations, but often heavily subsidized by state and federal grants (and often with such governmental mandates that administration can hardly be called "private").

How long will private practice be "private"? How relatively uninvolved in the rapid extension of health services to the indigent can the individual physician and organized medicine become before the growing tensions will evoke more federal intervention? Are we not risking the very fiber of the private practice of medicine by giving our opportunistic critics too much reason for criticism? Can we afford to be overly self-congratulatory until together we have formulated and affected a promising new and ambitious program of extensive health care and services reform? And, should it not be *our* reform, *our* revolution?

In Edward Kennedy's *In Critical Condition*, he presents scores of pathetic cases where people have lacked treatment, had poor treatment, or could not afford that which was available. The picture is a distorted one since it omits any real reference to the majority of Americans who regularly receive the world's best medicine.

His answer is a compulsory national health insurance program. He states quite emphatically "only the government can operate such an insurance program in the best interest of all people. We can no longer afford the (private) health insurance industry in America, and we should not waste public funds in bailing it out."

But if the trend for more socialized, federally financed and managed programs continues, our fate may be with a depersonalizing, insensitive and indif-



(Photo by Jack Corn)

THE APPALACHIAN PROBLEM

Malnutrition and tooth decay are commonplace to many of the children seen by Project Concern's medical and dental professionals in the Appalachian health care program in nearby central Tennessee. More than 1,000 patients are seen monthly in unique traveling vans which travel narrow, winding roads to reach the children of poverty stricken families.

ferent plan, a plan not of our choosing, not of our liking, and most likely, not to the advantage of its recipients.

The Provider's Heart

I was at a national meeting of the Student American Medical Association in Los Angeles last year. I was a guest speaker. Senator Kennedy gave the keynote address—which, expectedly, featured his version of the Health Maintenance Organization (HMO). The response was generous, but for such a young seemingly liberal group, I thought, restrained. There followed a question and answer period. One medical student asked the senator, "Mr. Kennedy, can any ambitious new program for health care delivery be successful until the hearts of the providers are changed?"

The huge auditorium was strangely silent. After a long pause, the senator agreed that, perhaps, this was the key.

We, the physicians, need to show care for our patients. Every time one of us sits patiently, listening, looking, feeling—we are furthering the cause of private practice. Each time a patient is treated abruptly, hurried along, his or her symptoms ignored or belittled, we are a step closer to HMO.

Listen to the critics of HMO, the very people who are supposed to be enjoying the grand advantages

of the "ideal" scheme. Harry Schwartz, in his *Case for American Medicine*, has interviewed scores of such recipients. "You wait and wait and wait." "I couldn't get an annual physical—it was degrading." "There was no privacy, I didn't feel I was being treated like a human being." We will be aiding and abetting our own human frailties of impatience, fatigue and personal gain, if we do not achieve a more suitable alternative than HMO.

Private practice in America is on trial. It is a trial that has lasted now for 200 years. It is not concluded. The jury has not retired. But the jury is tired, weary of inadequacies in a day and time when all know what might be available if they had only been "high born."

Eleven years ago I was in a good, productive private general practice in Southern California. For nearly five years I had tried to convince myself that these problems were not my problems.

Then one night, across the border in Tijuana, working as a once a week volunteer doctor in a small, shabby charitable clinic in the canyon slums, I saved two children's lives, children with severe bilateral bronchopneumonia.

All the old arguments about the impossibility of the task, what little difference my new role would make, that only the government could do anything significant, seemed remote and insignificant in light

SHOT / Turpin

of my personal joy and satisfaction in being a physician for those who might otherwise have no doctor they could afford. (There were 1,400 other doctors in San Diego County, but that day in Tijuana I was the *only* physician available to that little girl and her brother.)

What Project Concern has been able to do in 11 years may be "a drop in the bucket," but that drop, in terms of the coworkers and patients I have come to know has "washed my unconcern away."

Project Concern is totally private, spending not one cent of government money. We are not related to any church, believing that good modern care is apart from the very personal consideration of church membership. We are taking modern western medicine—with a few compromises—into remote and poorly cared for areas.

Getting Involved

In conclusion I have some recommendations:

1. That each county medical society sponsor at least one charitable clinic in its area (societies of 20 or more members), staffed by their membership.

2. That each physician and surgeon devote one week annually to a domestic or foreign charitable program. I refer you to your churches, federally financed projects, such as the Peace Corps, and private organizations such as AMDOC, LAOS, Hope—and, of course, Project Concern.

3. Endorsement of and active support for the physician assistant and or nurse clinician program.

4. Encouragement for plans which, if necessary, will divert some foundation and federal funds from research to clinical programs (there is a great deal of medical acumen and equipment—life saving—but which, although in use for years is not yet available to the disadvantaged).

5. Develop a plan for more equal distribution of physicians. I believe a National Service Corps in which graduating medical students, or at the conclusion of their post-medical school courses, would be required to spend two years in carefully selected disadvantaged areas, would be well worth your consideration.

6. Petition your state leadership to study several alternatives to pre-paid plans. The above ideas are only a few of those which may be valid alternatives.

We do not require scare tactics to convince us of the real threats to our treasured institutions. Neither do we need to be lulled to sleep by those who might persuade us that "God's in his heaven, all's right with the world."

The signs and symptoms of neglect and abuse are there. I believe the cure is here, too, in the form and fashion of Georgia physicians' accepting the tremendous challenges which today presents to us all. We hold the gun with the "magic bullet" of private care, voluntarily administered to everyone. It is the first shot that must be heard. It may be the only one necessary.

P. O. Box 81123 92138

NEUTRON THERAPY AVAILABLE TO GEORGIA CANCER PATIENTS

Neutron therapy, a promising form of treatment for some cancerous tumors, became available to Georgia residents in October through the Emory University Clinic.

Cancer patients from Georgia and six other eastern states and the District of Columbia will begin this month to take part in the program—one of two or three in the United States currently operational.

These treatments utilize a type of radiation called fast neutron beams created by a cyclotron to irradiate and destroy cancerous tissue much as x-rays and gamma rays are currently used for such treatments.

The project will help determine whether or not neutron radiation is significantly better than other types of

radiation in controlling or curing some types of localized tumors.

The treatments, to be administered at the Naval Research Laboratory cyclotron in Washington, D.C., are coordinated at Emory by John R. McLaren, M.D., associate professor of radiology and director of radiation therapy at the Robert Winship Memorial Clinic of Emory University Clinic.

Funds totalling more than \$1 million from the National Cancer Institute are supporting the extensive research and clinical studies. In the first year more than 200 patients are expected to receive treatments at the cyclotron. Patients will be selected by 18 physicians at radiation therapy centers in medical centers from Philadelphia to Atlanta.

Adrenal Cortical Carcinoma: A Case Report

JAMES C. JUDY, M.D. and PETER L. SCARDINO, M.D., *Savannah**

IT HAS BEEN POSSIBLE to depress the functional ability of the adrenal cortex since the work of Nelson and Woodard in 1949 in which they used the insecticide DDD to cause necrosis and atrophy of the adrenal cortex in dogs.¹ In 1952,² an isomer of DDD (Ortho Para DDD) was found to be less toxic yet 20 times more active than DDD. A few days after administration O,P'DDD degenerative changes occur in the zona reticularis and zona fasciculata.³

The purpose of this presentation is to record the treatment of a patient with advanced adrenal cortical carcinoma with O,P'DDD. The clinical and pathological aspects of adrenal cortical carcinoma are considered and a review of the concepts of treatment as applied to this case is discussed.

Case Representation

B. C., MMC (#216-364): A 48-year-old white female had a supracervical hysterectomy in 1949. Prior to the present Memorial Medical Center admission she had a trachelectomy at which procedure a large left retroperitoneal mass was encountered which involved the left ureter. The left ovary and Fallopian tube were removed. The ureter was ligated. The initial tissue removed was thought to be metastatic clear cell carcinoma.

Six months prior to the MMC admission the patient had lost 10 pounds in weight. For 10 years her hair distribution had changed and she noted progressive hirsutism. Five weeks prior to admission she received psychiatric treatment for depression. Left flank pain with fever and chills had been present for two to three weeks. Neither hypertension nor cardiac problems had been experienced.

Physical Examination Findings

Physical examination revealed a middle-aged white female appearing older than 48 years. She was

febrile and hirsute with sparsity of scalp hair. Her skin was scaly. The lungs were clear to palpation, percussion and auscultation. The heart examination revealed a grade 3-4 systolic murmur at the base. A large tender, irregular mass was easily felt in the left abdomen extending to the midline medially, to the diaphragm cephalad and to the iliac crest caudally. No adnexal masses were palpated. The clitoris was normal.

Laboratory studies were normal with exception of the urine and adrenal function studies. Urinalysis revealed pyuria and occasional red blood cells and a culture revealed *Proteus Mirabilis*. Plasma cortisol levels were obtained with the a.m. cortisol level of 26 and the p.m. 32.* The urinary 17 hydroxysteroid was 72 and 17 ketosteroids was 30.†

The chest x-ray was normal. An infusion pyelogram demonstrated downward displacement of the left kidney. Selective arteriography demonstrated neovascularity of the adrenal tumor (Figure 1A, 1B). Inferior venography demonstrated no obstruction.

The presurgical diagnosis was functional adenoma which had undergone malignant change. Surgery was performed through a thoracoabdominal incision via the tenth rib. The large mass extended behind the kidney into the bony pelvis. En bloc resection of the left adrenal, kidney and proximal ureter and spleen was performed. The mass itself weighed 2.2 kilograms. The postoperative course was uneventful.

The patient was followed with frequent determinations of cortisol levels. Five months after surgery she was re-admitted to the hospital because she was Cushingoid and in hypertensive crisis with a blood pressure of 240/140. Her BUN and creatinine were normal. With correction of the hypertension and electrolyte imbalance she improved. At this admission O,P'DDD was started. An initial primary dose

* From the Department of Urology, Memorial Medical Center in Savannah, Georgia.

* Normal values: 8-24 meq.

† Normal values: 17 HS 4-8, 17 KS 5-15.

of 1 gram was given followed by an equivalent amount four times daily. The dose was gradually increased to 2.5 grams four times per day at the time of her discharge. A liver scan obtained prior to the patient's discharge from the hospital was positive for metastatic disease (Figure 2).

During the outpatient visits the dosage of O,P'DDD had to be adjusted because of gastrointestinal distress. Four months after the O,P'DDD had been started the patient was re-admitted to the hospital with dehydration and weakness. She was in electrolyte imbalance but normotensive. Her condition deteriorated despite supportive measures. A postmortem examination was refused.

Discussion

Carcinoma of the adrenal gland can be classified as a functional or nonfunctional tumor. Functional had previously implied clinical diagnosis, but carcinoma of the adrenals may produce increased levels of steroids without necessarily causing virilization and/or cushionism. In classifying carcinoma as functional, laboratory evidence of production of steroids must be made. There is a preponderance of functioning adrenal tumors in females,^{4, 5, 7} perhaps because of the clinical features of hormonal excess, cushionism or virilization by 17 hydroxysteroids and/or ketosteroids respectively.

Non-functional carcinomas usually present with an abdominal mass, pain and/or metastasis.⁵⁻⁸ No laboratory evidence of increased androgen or corticoid excess is present, nor is any clinical evidence of functional tumor present. The incidence here is greater in the male.^{4-6, 8, 9} Also these tumors usually present at a later age than functional tumors. In one series,⁹ the average age of non-functional tumors



FIGURE 2

was 18 years older than the functional group. There is no predilection to right or left side. In one series,⁹ 22 out of 34 carcinomas occurred on the left side. The tumors vary from a few centimeters in diameter to much larger and often obtain weights of several kilograms.⁵ Grossly they vary in shape and have a soft consistency. On cut surface, areas of necrosis and hemorrhage can be seen.

Histologically adrenal cortical tumors vary from anaplastic lesions to rather benign tumors. Features such as cellular pleomorphism, nuclear hyperchromasia and frequent mitosis are present^{5, 6, 9, 10} (Figure 3). If there is evidence of capsular infiltration or invasion of venous or lymphatic channels the lesion usually is malignant.^{5, 6, 10}

Locally the tumor may invade the kidney, abdominal wall and blood vessels by direct extension

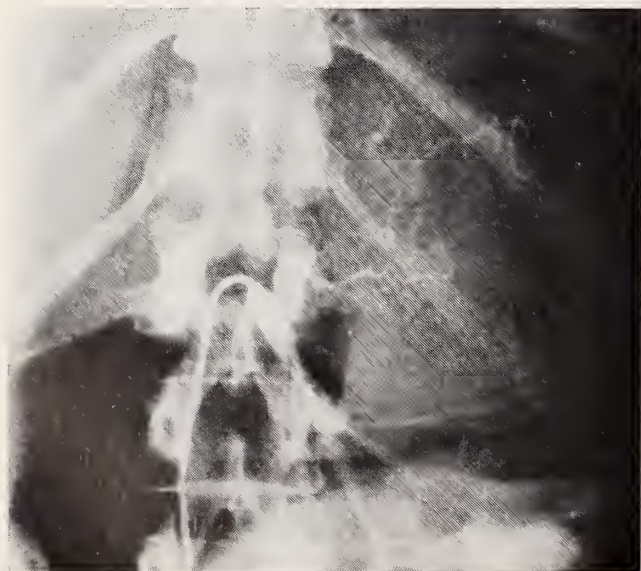


FIGURE 1A

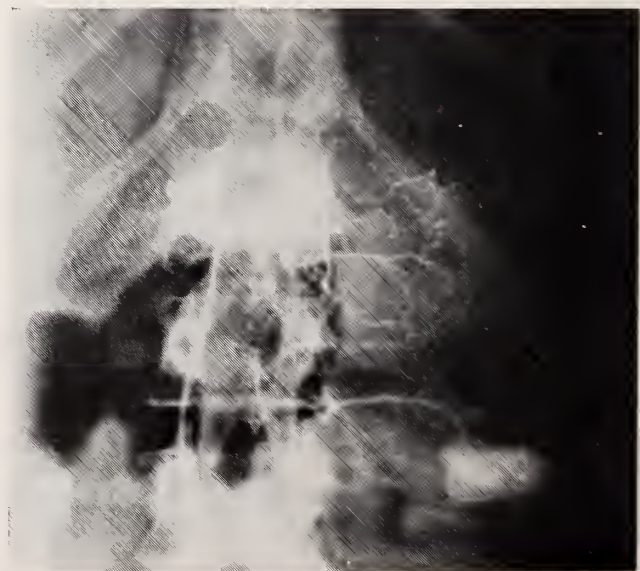


FIGURE 1B

or erosion from the enlarging mass. Distant metastases occur in the lungs, liver and lymph nodes.^{4, 5} Skeletal and central nervous system metastases are quite rare.^{4, 5}

Treatment of Choice

Surgical intervention, whether radical or palliative is the treatment of choice for carcinoma of the adrenals. Non-functional tumors usually present with pain or an abdominal mass, either of which would respond to palliative surgery, depending upon the extent of the metastasis.^{4, 6} If the tumor is localized to the adrenal gland then en bloc resection should be performed. If there is local involvement of the kidney, nephrectomy is the procedure of choice. Temporary return to normal level of hormones in functional tumor can occur with resection of tumor masses.^{6, 11}

The results of radiotherapy are disappointing.⁸ Satisfactory palliation is obtained by combining chemotherapy with surgical intervention.

Chemotherapy is useful in the treatment of inoperable adrenal carcinoma whether confined locally or with distant metastatic sites. Its clinical benefits have been shown by the steroid response, and measurable disease response. In the former, a value of less than 70 per cent of the pretreatment value was considered acceptable. Measurable disease response can be seen by reduction in the size of the primary and/or metastatic lesions. In one large series,¹² the steroid response and measurable disease response were 72 per cent and 34 per cent respectively. Within a month after initiation of therapy there should be a detectable trend toward normal in the level of steroids. If there is no response after a month, then the treatment is generally considered ineffective.¹²

Perhaps measurable disease response is a better indicator of clinical response than steroid response. Ortho Para DDD in most cases will lower hormonal levels, but it has been reported that an acceptable steroid response can occur without regression of the tumor.^{12, 13} The implication here is that the neoplastic process is independent of the steroid production.⁷ There appears to be a variable sensitivity of patients to O,P'DDD. Some patients are completely resistant to its effects.¹³ The implication here is that the neoplastic process is independent of the steroid production.⁷ There appears to be a variable sensitivity of patients to O,P'DDD. Some patients are completely resistant to its effects.¹³

Initiation of O,P'DDD is usually begun with lower dosages and gradually increased by small increments. The maximum dosage varies, and depends a great deal on the patient's tolerance for the drug. Most authors^{7, 12, 13} suggest a maximum daily dosage of 10 grams. This dosage is continued for variable

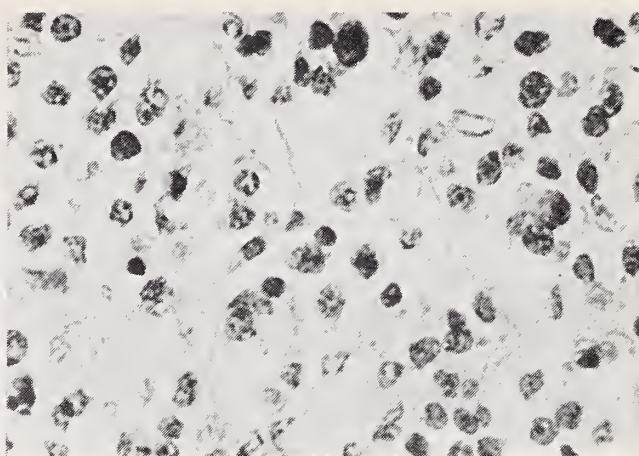


FIGURE 3

periods of time; often intermittently, if side effects developed. Reduction in the daily dosage will often lessen the toxic effects. Discontinuation of the drug is indicated if there is no acceptable response or if there is a severe toxicity. Gastrointestinal disturbances are primarily the distressing side effects of O,P'DDD.^{12, 13} These manifest as anorexia, nausea, vomiting and diarrhea. Neuromuscular disturbances and skin eruptions have been observed.¹² No bone marrow depression or liver toxicity has been reported.

Summary

A case of an adrenal cortical carcinoma is presented with all the stigmata of a functional tumor. The patient was initially treated with palliative surgery with a fair steroid response, later developed signs and symptoms of increased steroid activity and started on Ortho Para DDD. Her response has been presented, along with a brief resume of adrenal cortical carcinoma.

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HIGHLIGHTS OF MAG COUNCIL

September 22-23, 1973

Expenditure of Funds by Executive Committee: Authorized Executive Committee to expend up to \$2,500 between meetings of Council with any amount in excess to be retroactively approved by Council.

Appointments: Remer Y. Clark, M.D., Marietta, to Finance Committee.

Annual Session Format: Approved 2½ day business format for Annual Session in May and two-day Scientific Session for October. New format to become effective in 1974. Also approved moving of Business Session from May to April, effective 1975.

Report of Insurance and Economics Committee: Approved termination of Life Insurance Company of Georgia program effective November 15, 1973 with transfer and implementation of MAG insurance to Southern Medical Association Insurance program.

Georgia Medical Care Foundation: Received report on Foundation On-site Nursing Home Program and development of Certified Hospital Extension of Care (CHEC) program. Received notification of expiration of Foundation Board of Directors' terms of office in December and need to appoint new Board at January Council meeting.

PSRO: Received report from Committee on PSRO and approved its budget in the amount of \$3,585. Discussed placing PSRO as item on Special Session Agenda.

EMCRO: Received report from EMCRO Committee concerning status of Committee's review of EMCRO. Discussed recommendation to hold Special Session of

the House of Delegates in December to consider making EMCRO operational.

Special Session, MAG House of Delegates: Voted to call Special Session for discussion of EMCRO and PSRO for December 15 and 16, Marriott Hotel, Atlanta.

Legislative Committee Report: Referred to Executive Committee consideration of change of MAG position on certificate of need legislation with information to be presented to Council in January. Requested preparation of legislation to establish Medical Examiner system, replacing coroner system in Georgia. Requested representatives from Georgia Academy of Pediatrics to appear at Council in January to discuss change of MAG position on compulsory inclusion of newborns in all health insurance.

Intern and Resident Dues: Set dues rate at \$10 per year for interns and residents as active members of MAG.

Medicare Hearing Procedure: Endorsed resolution from Richmond County Medical Society challenging Medicare regulations establishing fair hearing procedure. Instructed submission of similar resolution to AMA House of Delegates.

Temporary Permit for Foreign Medical Graduates: Recommended to Board of Medical Examiners that temporary permits not be extended to foreign medical graduates or others who have failed medical licensing examination.

Charges that medical organizations block adequate medical care are termed "irresponsible."

MAG Spokesman Defends Georgia Physicians

HARRISON L. ROGERS, M.D., *Atlanta*

Speaker, MAG House of Delegates

(Ed. note: The statement below was issued to the news media September 27, 1973, the day following published reports that Gov. Jimmy Carter, speaking at the Southern Governors' Conference in Point Clear, Ala., had criticised Georgia physicians and the MAG on several points.)

GENTLEMEN, good morning, I am Dr. Harrison Rogers, Speaker of the House of Delegates of the Medical Association of Georgia. We have invited you here today to hear our response to charges made by Governor Jimmy Carter about the adequacy of medical care in the state and other matters.

In his statement released yesterday, the Governor said that the Medical Association of Georgia had consistently opposed his efforts to broaden medical care programs through his reorganization plan. Only occasionally did the Governor ever consult with MAG or any of our members about the medical profession views on the reorganization of the health board, and then paid little heed to the recommendations given.

The Governor also commented that collectively, organized medicine had done more to block adequate medical care for the people of this country than any other single group. We consider this to be totally irresponsible.

Getting to Specifics

It is very easy for the Governor to make such a statement, but it would be very difficult for him to tie this down to specifics. Does he mean that medical care costs are rising too high? In the first 12 months of price controls, the cost of living over-all went up 2.9 per cent. Medical care services over-all went up 2.6 per cent. Does he mean that doctors are not available to the people? No Georgian is more than 25 miles from a medical facility.

Does he mean that the medical profession is practicing professional birth control? Then, I respond to

the Governor by saying that 23 of the 112 U.S. medical schools have been opened in the last six years. The British, by contrast, have opened only two medical schools since the end of World War II. There are currently some 20,000 medical students, interns, and residents in the United States, many from minority groups, whose education is now and has been since 1961, financed in part by loans guaranteed through the American Medical Association; hardly an example of professional birth control.

Physician Assistants

In another statement we consider irresponsible, Governor Carter said, "They are trying to block in every way possible the spread of responsibility for medical care to P.A.'s who are graduates of Emory Medical College and who are highly competent." Two points should be noted in this regard. First, the initial Emory graduates were hospital-based physician assistants, who though highly skilled, provided a limited scope of medical services. Secondly, assistants to the primary care physician will not be available from Emory until December. Only then will they begin to meet the real need for increasing physician productivity, thus improving the availability of care to all Georgians.

Through our placement program, and our individual members, we have been instrumental in placing a number of these physician assistants, and putting the credentials of the rest before our membership. But, I think more background information about MAG and physician assistants would be appropriate at this time. As early as 1969, the Medical Association's Regional Medical Program became involved in programs to develop physician assistants type personnel. That year, a program was begun by Grady Hospital to develop medical specialty assistants, such as coronary care assistants. In 1971, a transition program was begun with Emory University to get paraprofessionals from various hospitals

integrated into the Physician Assistants program. Later, funding was provided to the Medical College of Georgia for the development of their program. All total, since 1969, in excess of \$200,000 has been expended through MAG for the development of physician assistants programs. As you know, there is a physician assistants program at Georgia State University, which Dr. Rhodes Haverty heads. He is eminently familiar with the activities that have transpired relative to physician assistants programs, and can respond to any specific questions.

Protective Legislation

In the early stages of considering physician assistants legislation, our concern stemmed from the fact that inadequate controls were placed on the individuals to be certified as P.A.'s. We assisted in drafting what we consider to be a better piece of legislation, putting the P.A. under the supervision of

the physician he works for, thus assuring that the physician knows exactly what his assistant does. Additionally, the legislation provides that no physician may have more than two physician assistants. This was done in the belief that larger numbers of P.A.'s could not be properly supervised, thus potentially jeopardizing quality of care.

We support the orderly and intelligent use of physician assistants, and any inference to the contrary, on the part of the Governor or anyone else, is a gross misrepresentation of the facts.

We have tried very diligently to work with all interested parties in solving Georgia's medical problems. We will continue to do so. A carte blanche indictment of the Medical Association of Georgia, or doctors in Georgia, or medical organizations in general is irresponsible. It is certainly not in the spirit of providing the best medical care, or working together in harmony to solve the problems that exist.

That concludes my prepared statement, and now I'll be glad to answer any questions that I can.

HIGHLIGHTS OF MAG EXECUTIVE COMMITTEE OF COUNCIL

September 22, 1973

MAG Headquarters Building: Received report on offer for land adjacent to MAG building. Referred to Building and Land Committee for report in October.

County Medical Society Charters: Approved consideration of issuance of new charters to existing county medical societies.

Newborn Insurance: Approved in principle, supporting by whatever means necessary the inclusion of newborn coverage in all insurance policies directing Legislative Committee to investigate and report by November.

Nurse Practitioner: Received report on functioning of nurse practitioner in Pearson. Requested additional information from members of Coffee County Medical Society regarding their relationship with the nurse practitioner.

Change in Medical Practice Act: Referred to Legislative Committee consideration of amending Medical Practice Act to eliminate exclusion of nurses and nurse midwives.

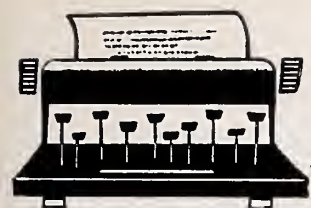
Resolution on School Food Service: Approved support of provision that only nutritious food be served in the schools.

MAG Representation at State Medical and Allied Health Meetings: Approved concept of an MAG officer or representative attending state wide meetings sponsored by medical or allied health organizations to present welcoming remarks on behalf of MAG.

AMA Volunteer Physicians for Viet Nam: Referred to Committee on Awards consideration of issuance of Letter of Commendation by MAG to Georgia physicians participating in the AMA Volunteer Physicians for Viet Nam program, Project Hope physicians and volunteer physicians for other such programs.

Appointments: Committee on Maternal and Infant Welfare—chairman, Luella Klein, M.D., Atlanta and Daniel B. Stephens, M.D., Marietta; Committee on PSRO—James H. Sullivan, M.D., Columbus; Subcommittee on Medicine of Committee on Education—William H. Stewart, M.D., Atlanta and James L. Achord, M.D., Macon; Committee on Geriatric Medicine—Donald J. Welter, M.D., Augusta, Bernard H. Palay, M.D., Atlanta and Joseph Pacifici, M.D., Savannah.

Next Meeting: 9:00 a.m., Sunday, November 4, 1973, Atlanta Internationale Hotel.



Service—One Man's Synonym

ALL WHO HAVE HAD THE PRIVILEGE of contributing to our Association's journal seem inevitably to address themselves to one common problem. That problem is the general lack of involvement in organized medicine and community affairs by our colleagues.

In defense there is probably no single group so fully occupied with the needs of people or so weighted down with responsibility for their very lives. Notwithstanding this however, our profession trains us well for these tasks and every facet of our community comes to us regularly for our support and for our service.

On October 6 we lost a man whose very name called up to each of us our own view of service—not the simple lip service we so often provide, but honest, dedicated and responsible service. He was Dr. J. Frank Walker of Atlanta.

Frank began his service to medicine shortly after joining the Fulton County Medical Society in 1953. His first assignment was on the Legislative Committee followed by his election as a Junior Member of the Board of Trustees. To each position he gave his very best efforts. Not only was his personal service of great value, but he attracted many others to this common cause by his good example.

With proven capabilities and a willingness to serve, he moved into an active role in our state Association, ultimately serving as speaker of the House of Delegates for eight years. With his election as Delegate from Georgia to the AMA another era of responsible service began which subsequently culminated in his election as speaker of the House of Delegates of the AMA in 1972. Throughout this era he continued to serve on committees of the local, state and national associations with good judgment and responsibility always his "hallmark."

During this same productive period he was closely associated with his church, attending regularly as well as serving as Deacon and Elder. Here too he gave more than "lip service," for he took time to join in the hard work that goes into such an organization. He spent many evenings traveling about our city proselyting for his faith; meeting with old and young who had come to the church because they had no church of their own. In addition there were endless demands of Frank by all manner of civic groups, and each profited greatly by his presence.

His response to the needs of his specialty society was equally vigorous and productive and in 1969 he was elected president of the American College of Radiol-



ogy. His support of his alma mater was equally unselfish and resulted in his election as president of the Medical Alumni, president of the National Alumni Association and finally to the Board of Visitors of Emory University.

The list of his accomplishments is overwhelming and becomes remarkable when one considers that it all happened in a 20-year time frame. Probably the most outstanding attribute of this career of service was not the specific job itself, but rather the overall standard that he maintained for each of us—a standard of dedicated and responsible service.

His leadership will be greatly missed.

Harrison L. Rogers, M.D.

PHYSICIANS' HELP ASKED ON NEW FEDERAL PAYMENT PROGRAM TO DISABLED

On January 1, 1974, a nationwide program of direct Federal payments to aged, blind or disabled persons with limited income and resources goes into effect. Known as "Supplemental Security Income" (SSI), the new program will have uniform eligibility requirements for such persons to replace the multiplicity of requirements existing under the present Federal-State Public Assistance Programs.

The Supplemental Security Income Program will be wholly financed from the Federal general tax revenues. Responsibility for administering the program has been given to the Social Security Administration. The Georgia Vocational Rehabilitation Disability Determination Unit will be responsible for securing medical evidence and making a disability determination as they now do for workers or dependents who apply for Social Security Disability Payments.

The SSI Program will generally use the same definitions of disability currently used in the Social Security Disability Insurance Program.

All persons whose applications for determinations

of disability are adjudicated in the Georgia Disability Determination Unit are referred to Vocational Rehabilitation for consideration of rehabilitation services.

With anticipated doubling of the Georgia Disability Determination Unit workloads, emphasis is being placed on expanding resources within the medical community in order to secure medical reports needed for adjudication of claims as quickly as possible.

Even though payments will not begin until January, 1974, the Georgia Disability Determination Unit is now receiving claims under this program and will be contacting the medical community for their assistance concerning medical information on their patients. Implementation of the Social Security Income Program will undoubtedly give rise to new questions and point out areas of concern with the respect to the medical community and the Georgia Disability Determination Unit. Further information can be obtained from: Vocational Rehabilitation, Disability Determination Unit, One West Court Square, Suite 300, Decatur, Georgia 30030.



WE MOURN; LOOK TOWARD THE FUTURE

ORGANIZED MEDICINE HAS LOST one of its most ardent and active supporters and many of us have lost a close personal friend.

Frank Walker of Atlanta died October 6. Frank was one of MAG's delegates to the American Medical Association and was speaker of the AMA House of Delegates until he was forced to resign because of ill health prior to the AMA Annual Session earlier this year. Prior to his election as speaker, he served as vice speaker of the House for three terms. Frank served as president of the Fulton County Medical Society and as president of the American College of Radiology.

We have lost a friend and colleague whose counsel and support we cannot replace. His untimely death has created a void that will be evident for many years.

On Saturday and Sunday December 15 and 16, 1973, a special called session of the MAG House of Delegates will be convened at the Marriott Motor Hotel in Atlanta for approval or disapproval of Experimental Medical Care Review Organization (EMCRO) project.

EMCRO has been and is now being studied and evaluated by a special committee on EMCRO under the able leadership of Ollie O. McGahee of Jesup. This committee will report to the delegates its findings concerning this controversial subject. However, I hear rumblings that perhaps EMCRO will not be so controversial when we hear this committee's report, and many half-truths and suspicions will be dispelled. Let us hope so.

Professional Standards Review Organization (PSRO) will be discussed also. Dr. Charlie Hollis' special committee on PSRO will give a report which will be followed by an information and discussion period.

Your officers and headquarters personnel expended many hours in an attempt to get the Department of Health, Education and Welfare to designate the state as a single PSRO. We do not know yet what will happen. We have pleaded in good faith for a single, state-wide PSRO. We have exhibited facts and figures to support our contention that we can function best with all of Georgia's physicians doing review on a local level, but within a large single, state-wide organization. The bureaucrats seem, in my opinion, more interested in creating more bureaucracies.

I implore each member of MAG to attend your local medical society meeting between now and December 15 so that you can intelligently instruct your delegates regarding these most crucial issues.

A handwritten signature in cursive script, reading "Charles E. Bohler, M.D.".

*Charles Emory Bohler, M.D.
President, Medical Association of Georgia*

OFFICIAL CALL

To the officers and members of the MEDICAL ASSOCIATION OF GEORGIA for a special session of the House of Delegates December 15-16, 1973 at the Marriott Motor Hotel in Atlanta, Georgia.

To Consider:

**Experimental Medical Care Review Organizations (EMCRO),
and
Professional Standards Review Organizations (PSRO)**

SCHEDULE

Saturday, December 15, 1973

8:00 a.m.—Registration opens	12:00 p.m.—County medical society caucus
9:00 a.m.—First Session, House of Delegates	luncheons
Remarks of the Speaker	
Presentation of reports and resolutions on EMCRO	2:00 p.m.—Reconvening of the House of Delegates
Report on findings of the Committee on EMCRO	Discussion period
Discussion period	Voting
Recess	Adjournment

Sunday, December 16, 1973

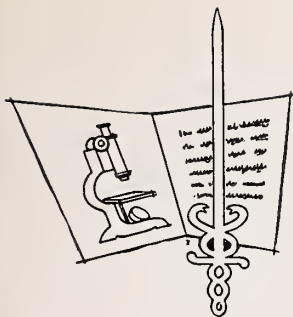
9:00 a.m.—Second Session, House of Delegates	12:00 p.m.—County medical society caucus
Remarks of the Speaker	luncheons
Presentation of reports and resolutions on PSRO	2:00 p.m.—Reconvening of the House of Delegates
Report of the Committee on PSRO	Discussion period
Information and discussion period	Voting
Recess	Adjournment

Delegates' materials, registration information and room reservation cards at the Marriott Hotel have been mailed to all members of the House of Delegates. A copy of the EMCRO grant proposal, as well as a financial statement, has been sent to each county medical society and all delegates.

County medical societies and members are urged to submit resolutions to MAG Headquarters by December 1 so that copies of the resolution will be available for all delegates at the actual time such resolutions are introduced.

Two caucus luncheon meetings are necessary to discuss the subject matter on December 15 and 16 before voting when the House reconvenes each day. Meeting rooms for the seven large county medical societies have been reserved: Bibb, Georgia Medical, Cobb, DeKalb, Medical Association of Atlanta, Muscogee and Richmond.

**C. Emory Bohler, M.D., *President*
Harrison L. Rogers, Jr., *Speaker*
Ernest C. Atkins, M.D., *Secretary***



AMERICAN CANCER SOCIETY POLICY STATEMENT ON THE SURGICAL TREATMENT OF BREAST CANCER

LAMAR S. MCGINNIS, M.D., *Decatur**

THE FOLLOWING IS A POLICY STATEMENT approved by the National Board of Directors of the American Cancer Society, on the recommendation of the Medical and Scientific Committee, that a detailed, comprehensive statement on the surgical treatment of breast cancer be adopted.

This statement is being printed herewith in its entirety because of the confusion that has arisen in the minds of many of our patients by virtue of the many lay articles that have appeared on the subject in recent years, and is the feeling of those physicians involved on our Georgia Division Board of Directors.

"Breast cancer will affect one of every 15 women in the United States at some time during their lives and it remains the leading cause of cancer deaths in women.

Important Steps Being Forgotten

"A current controversy over the surgical treatment of breast cancer has tended to divert attention from the importance of early diagnosis through breast self-examination, and periodic physical examination of the breast by physicians, aided by newer diagnostic advances.

"Pending clear proof that equally good results can be achieved by limited procedures less than mastectomy, the American Cancer Society believes that the public should not be misled into accepting less proven methods.

"The American Cancer Society has dedicated itself to promoting the control of breast cancer. The immediate major effort of such control has been in the field of early diagnosis. The selection of this special area of activity was made because the proven methods of therapy are highly effective (85 per cent to 90 per cent survivals at five years) when the diagnosis is made at an early stage and treatment is prompt. There is now reason for concern by the Society that some of the benefits of early diagnosis are being lost by inadequate and unproven methods of treatment.

"Even when breast cancer is found early at least 20 per cent of the cancers have already spread to adjacent lymph nodes. At present, there is no completely satisfactory method of identifying those tumors which have already undergone limited extension, and those which have spread beyond the confines of customary treatment. While studies continue in many disciplines on these exceedingly important questions, we must understand the nature and description of the various methods of treatment of breast cancer which apply to the tumor itself.

"1. Extended Radical Mastectomy or Supra-radical Mastectomy—surgical re-

* Dr. McGinnis serves as chairman of the Professional Education Committee, American Cancer Society, Georgia Division, Inc.

removal of the internal mammary chain of lymph nodes, the entire involved breast, the underlying chest muscles and the lymph nodes in the axilla (armpit).

"2. **Halsted Radical Mastectomy**—surgical en bloc removal of the entire involved breast, the underlying chest muscles and the lymph nodes in the axilla.

"3. **Modified Radical Mastectomy**—surgical removal of the entire involved breast and many lymph nodes in the axilla. The underlying chest muscles are removed in part or are left in place after removal of the nodes in the axilla.

"4. **Simple Mastectomy (more recently called Total Mastectomy)**—surgical removal of the entire involved breast. The underlying chest muscles and lymph nodes in the axilla are not removed.

"NOTE: All of the above procedures remove the involved breast completely.

"5. **Limited Procedures**—have received a variety of names including lumpectomy, local excision, partial mastectomy, tylectomy (comparable to lumpectomy). In each instance the tumor is surgically removed with a varying amount of surrounding tissue.

Historical Data

"For many years surgeons have preferred the Halsted radical mastectomy as the operation of choice for most cancers of the breast. More recently, some surgeons have preferred the modified radical mastectomy for early cancers, or a simple mastectomy for in-situ (extremely early and non-invasive) breast cancer. Subcutaneous mastectomy with subsequent implant has been recommended also for lobular carcinoma in-situ but *not* for invasive cancer.

"Recently, publicity has been sought about the possibility of not removing the breast and using limited procedures instead, with or without post-operative radiation therapy, for some cases of breast cancer. The basis for recommending limited surgery rests on reports of only a few studies, particularly those done outside the United States, which suggest that survival from breast cancer discovered *early* and treated by limited surgery plus radiotherapy is equal to the results of removal of the entire breast. However, minimal surgery must be consistent with prolonged survival, freedom from recurrence and a satisfactory cosmetic and functional result.

"Surgeons who favor removal of the entire breast and the lymph nodes in the axilla do so because this procedure has consistently offered a very satisfactory survival rate for early cancer. Also, this technique allows for the removal of multicentric cancers frequently found in other parts of the same breast as well as cancer which often involves the axillary lymph nodes and cannot be detected by physical examination. The surgical principle here is the removal of all possible existing cancer within the scope of the operation.

New Techniques Await Study

"Studies on the various techniques of treatment of primary operable breast cancer are now underway in a number of U.S. institutions. However, it will take several years before the results are available. In the meantime, the policy of the American Cancer Society is the following:

"1. Removal of the entire breast (most often the radical or modified radical mastectomy) is recommended for the surgical treatment of operable breast cancer.

"2. Limited surgical procedures which remove less than the entire breast have not been scientifically proven to be as effective as mastectomy.

"3. Recommendations for the treatment of breast cancer should be made by the physician on an individual basis only after careful evaluation aided by diagnostic studies. Such recommendations are related to the type, size, location, extent of tumor and other pertinent factors.

"4. The patient and selected members of the family should be thoroughly ad-

vised by the physician about the proposed surgery and its rationale; this being the essence of informed consent.

"5. The American Cancer Society is committed to rehabilitate the patient following surgery for breast cancer. The Society has developed the 'Reach to Recovery' program which, at the request of physicians, sends trained volunteers who have had a mastectomy and have adjusted well, to visit mastectomy patients in the hospital. This program now brings information, psychological, cosmetic and physical rehabilitation to about one of every two women undergoing mastectomy in the United States. The Society takes the position that most of the physical and emotional problems related to mastectomy can be offset by planned rehabilitation. This, plus every reasonable chance for cure, is the right of every woman who develops breast cancer.

"6. The American Cancer Society is continuing its support of research into the causes, detection, diagnosis and treatment of breast cancer as one of its highest priorities. It is our belief and hope that the tragic toll from this disease can be prevented by early diagnosis and early treatment. We also believe that American women should be well informed about these medical matters so that they may intelligently discuss these important considerations with their respective physicians.

"7. Finally, any patient having breast cancer or indeed suspecting that she may have breast cancer, should consult a physician who is knowledgeable in this field, seek his advice and rely on his judgment in the selection of treatment for her individual medical situation."

365 Winn Way 30030

JAMAICA NEEDS RADIATION THERAPISTS

The West Indies island of Jamaica has an acute shortage of radiation therapists for cancer patients. To help relieve this shortage an Emory University professor is coordinating a new program in the U.S. and Canada.

The program is supported by a grant of \$16,500 from the Jamaican government and by a separate grant of \$8,500 from the American Cancer Society, according to Dr. John R. McLaren, chief of radiation therapy at Emory's Robert Winship Memorial Clinic and associate professor of radiology, Emory University School of Medicine, Atlanta, Ga. 30322.

Third-year residents in radiation therapy in the U.S. and Canada, if recommended by their chiefs of service, may be rotated at three-month intervals through the radiation therapy facilities in Kingston, Jamaica. The program will last two to three years.

These residents will teach in the West Indies Medi-

cal School and in the Kingston Public Hospital. They will also assist the island's only radiation therapist, Dr. Vernon Spence, in managing the heavy cancer load from two million Jamaicans plus inhabitants of surrounding islands.

Offered to qualified residents is round-trip air fare to Kingston; an apartment in Kingston; ground transportation in Jamaica; a stipend to be paid by the Ministry of Health in Jamaica; and an additional monthly subsistence allowance provided by the American Cancer Society.

The patient load in radiation therapy in Kingston is 70 to 80 cancer cases per day, Dr. McLaren said. It is heavy on cervical cancer. Also, there are sizeable numbers of head and neck, pediatric, thoracic, central nervous system, and other types of malignancies to be treated, he added.



DIAZOXIDE

MARTIN L. THRONE, M.D., *Atlanta**

THE DECISION TO RAPIDLY lower an elevated blood pressure must be based upon the knowledge of the abruptness of the pressure rise, and the presence of life-threatening cardiac, central nervous system or renal complications. The presence of any of the following, in the presence of a markedly elevated blood pressure, constitutes a hypertensive emergency:

1. Hypertensive encephalopathy.
2. Pulmonary edema.
3. Coronary insufficiency.
4. An acute decrease in renal function.
5. Grade IV retinopathy (papilledema).

Before treatment is started, it is important that a complete drug history be obtained: that is, has the patient been on an anti-hypertensive, psychoactive agent, monaminoxidase inhibitor, or pressor, which can precipitate a hypertensive crisis, or modify the response to treatment?

Return Diastolic Pressure

Our aim in lowering the blood pressure is not to make the patient normotensive, but to return the diastolic pressure to a level approximately 100-105 mm. of mercury, as a more abrupt decrease in blood pressure might sacrifice perfusion to vital organs. Thus, it is imperative, when rapidly lowering blood pressure, to monitor central nervous system, cardiac, and renal function.

Diazoxide, a non-diuretic thiazide derivative, has been available for the past 11 years, since being synthesized in 1962. It has, however, just been approved this year by the Food and Drug Administration for use in treating the hypertensive crisis (as Hyperstat). It must be administered as a single (300 mg.) intravenous bolus injection in a period of less than 15 to 20 seconds. This will produce a rapid fall in blood pressure, with maximum effect usually within three to four minutes. Hypotensive episodes are rare. The duration of action is usually three to eight hours, although occasionally lasting up to 24 hours.

Sellers and Koch-Weser have suggested that the reason Diazoxide is effective only when given as an intravenous bolus is that the drug is 90 per cent bound to albumin in the usually therapeutic concentrations after intravenous infusion. The remaining 10 per cent remains free in the plasma, and represents the active form of the drug. Therefore, hypothetically, slow intravenous infusion allows redistribution of the drug into the total blood volume, saturating the protein binding sites and not allowing enough free drug to produce a hypotensive effect. In summary, it is proposed that a high concentration of unbound Diazoxide must be delivered to the arteriolar smooth muscle active sites to produce maximal arteriolar dilatation.

Effects and Reactions

Diazoxide produces a rapid and prolonged fall in blood pressure by relaxing peripheral arteriolar smooth muscle, pre-capillary resistance vessels, leading to ap-

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

proximately a 40 per cent decrease in total peripheral resistance. An increase in cardiac output, secondary to reflex compensatory response to the rapid fall in total peripheral resistance, occurs. The drug also has an anti-diuretic effect, with marked sodium and water retention in both normotensive and hypertensive subjects. This leads to an expansion of blood volume, and in patients with myocardial insufficiency, frank edema. This action is diametrically opposed to the other thiazide congeners. There is, however, no antagonism between the two in regard to antihypertensive action, and this in fact is the rationale for the concomitant administration of a thiazide diuretic, or furosemide (Lasix) with Diazoxide.

Hyperglycemia is another side effect of Diazoxide, and is apparently due to inhibition of insulin release from the beta cells of the pancreas. This is observed frequently after prolonged oral administration, but infrequently following acute intravenous use. Thus, the drug has proved useful in the management of juvenile hypoglycemia.

Diazoxide produces an increase in plasma renin. Its action in preventing the completion of active labor is overcome by the use of oxytocics, and thus its use is not precluded in treating the hypertension of toxemia of pregnancy. Nausea and vomiting are rarely reported as are hypertrichosis and hyperuricemia (with prolonged oral use).

In summary: because of its rapidity and effectiveness of action, its relative safety, and since its effective dose does not have to be titrated, Diazoxide would appear to be the drug of choice in treating the hypertensive emergency.

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QUALIFIED RETIREMENT PLANS MAJOR CHANGES PROPOSED IN NEW SENATE BILL (or, Here We Go Again)

J. WINSTON HUFF, *Atlanta**

(NOTE: Since the type was set for this article, the House of Representatives has made a number of changes in H.R. 4200. Just how the Bill will finally come out is anyone's guess, but it does appear we are headed for major changes in the existing law.—J.W.H.)

OVER THE YEARS, self-employed professional persons have had difficulty in planning for retirement. First of all there seemingly has been an unfavorable federal attitude toward equal treatment for the self-employed. Also, from time to time, changes in federal tax laws governing retirement plans have required programs to be reviewed and revamped.

Physicians will remember well that for a long time they, along with other professional persons, were discriminated against. Federal tax laws (Keogh or H.R. 10) permitted the self-employed to set aside, tax free, in qualified plans the lesser of \$2,500 or 10 per cent of earned income. At the same time their corporate friends were entitled to a much larger deduction for such contributions. Then state laws began to permit the incorporation of professional persons. Physicians abandoned their Keogh plans, set up professional corporations and adopted the more generous corporate plans. The Internal Revenue Service resisted this move but finally gave in. This change in IRS attitude greatly accelerated the movement to professional corporations. Although the corporate form of practice has other benefits, the principal reason behind incorporation seems to have been the larger contributions permitted to qualified corporate retirement plans. No small amount of money was paid to attorneys, accountants and investment counselors for incorporation and retirement plan services in the belief that the dust had finally settled on this subject.

Nevertheless, in Washington the pot continued to boil. As early as 1969, efforts were made in Congress again to change the laws governing retirement plans. Also, instances of abuse were widely publicized and this gave impetus to these efforts.

Principal Features Reviewed

The latest Congressional move in this area is embodied in H.R. 4200, which passed the Senate on September 19, 1973, and thus is further along the legislative track than any of its predecessors. This Bill makes major changes in the law. If it is finally adopted by both Houses and Congress, it will affect in one way or another all existing and future retirement plans. Also, because it substantially increases permissible Keogh plan deductions, it will be an important consideration in determining whether to incorporate in the first place. This Bill is to be known as the "Retire-

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

ment Income Security for Employees Act" and it is very long and very complicated. Some of the principal features of H.R. 4200 are:

1. Proprietary Employee:

A new legal animal is to be created—the "proprietary employee." If an employee owns 2 per cent or more of the stock of his corporation and if he and his fellow 2 per cent shareholders are entitled to more than 25 per cent of the retirement plan, then that person is a "proprietary employee." If you are a proprietary employee, certain results attach, several of which are mentioned below. Many, if not most, of the physician employees of professional corporations will fall into the "proprietary employee" category.

2. Limitation on Contributions and Benefits:

The maximum tax free contribution a corporation may make to its retirement plan in any year on behalf of a proprietary employee is the lesser of \$7,500 or 15 per cent of that person's earned income. This is a substantial reduction from present limits. Also, new limitations have been placed on the yearly amount which may be paid out upon retirement, with special restrictive provisions governing proprietary employees.

3. Keogh Plans:

The maximum yearly deductible contribution which can be made per employee to a non-corporate self-employed plan has been raised to the lesser of \$7,500 or 15 per cent of earned income. Since this limit is to be the same as for corporate "proprietary employees," incorporation for physicians may not be as attractive as in the past.

4. Participation:

To be "qualified" under federal tax law, a plan must provide for participation by an employee no later than his thirtieth birthday or completion of one year of service with his employer.

5. Vesting:

To be qualified the plan must provide for "vesting" of 25 per cent of an employee's account after five years of service, with an additional 5 per cent vesting each year for the next five years and 10 per cent per year for the following five years. Thus, after 15 years, the employee's retirement account will be fully vested.

6. Funding:

These changes are highly complex. Basically, the Bill will require that, as to all accrued benefits, current service costs be fully funded on a current yearly basis and initial past service costs be amortized over 30 years.

7. Portability:

There has been much discussion concerning problems encountered when an employee leaves his employment. Termination of employment most often resulted in an immediate distribution of the employee's account, having adverse tax results to him. The Bill would set up a "Pension Benefit Portability Fund." Employers may voluntarily deposit into this fund the retirement account of a former employee to be held and distributed at a later date under rather complex arrangements.

8. Plan Termination Insurance:

A portion of this Bill concerns those situations where a retirement plan is terminated and the plan does not have sufficient assets to pay vested benefits. A federal corporation is created, under the supervision and direction of the Secretary of Labor, known as the "Pension Benefit Guaranty Corporation." This corporation will insure the payment of vested retirement benefits in the event of termination of a retirement plan. Eventually all retirement plans will have to become insured by this corporation and pay certain premiums for this coverage.

The Bill also would add definite employer liability where, upon termination, a plan is unable to meet its obligations to its participants. If a plan is terminated and the Pension Benefit Guaranty Corporation has to make good any vested benefits, the employer will be liable to this federal corporation up to the lesser of the amount

so paid out by it or 30 per cent of the employer's net worth. This can be avoided in some cases by paying extra premiums to this federal insurer.

9. Fiduciary Standards:

The Bill establishes strict statutory standards governing the activities of plan Trustees and those who control the operation of the plan. These standards cover investments, sales, loans, leases, and the like, especially such transactions between the plan and the employer and other interested parties. A special tax is levied on prohibited transactions and the Secretary of Labor is authorized to sue those involved for a loss resulting from a breach of these standards.

10. Enforcement and Supervision:

The Department of Labor is given enforcement powers over matters of vesting, fiduciary standards and plan terminations. The Bill also establishes, within the IRS, an "Office of Employee Plans and Exempt Organizations," with a new Assistant Commissioner of Internal Revenue to oversee qualification of plans, deductibility of contributions, funding standards and prohibited transactions.

What has been said is by no means a complete report on H.R. 4200. This Bill is 296 pages long and for each provision there are exceptions, exceptions to exceptions and special rules for special situations. This brief article is intended only to alert physicians that major changes will be made if this Bill becomes law.

H.R. 4200 must now go back to the House of Representatives. What changes may be made there or in Conference Committee are not known. It seems probable, however, that Congress will adopt major changes in retirement plan law. Physicians must be alert to these changes and the effect on their own retirement programs.

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EMORY GETS RECORD ENROLLMENT OF NEW MALE NURSING STUDENTS

Six male students are enrolled as newcomers in the baccalaureate program of Emory's Nell Hodgson Woodruff School of Nursing. It's the largest male contingent ever greeted at the school, and it represents a sharp increase over last fall's entering male population of one.

The men are part of the largest baccalaureate class in the Emory nursing school's history—a total of 95 students from 18 states. Last fall's entering enrollment was 83. Meanwhile, two of the 45 graduate students this fall are men.

Graduate enrollment was down from previous years, according to school officials, because of the withdrawal of federal support of graduate nursing programs and increased graduate tuition costs.

However, the officials said the 45 total in the new

graduate nursing class was "beyond all expectations" considering the financial problems. They said the beleaguered program was helped by a new plan of part-time work and study for graduate students and by greater recruitment activities on the part of the nursing school.

Twenty per cent of the entering baccalaureate class at Emory hold baccalaureate degrees in other fields of study. Normally, entering baccalaureate students spend junior and senior years in the nursing school after completing freshman and sophomore work at Emory College, at Oxford College of Emory University, or at other colleges and universities. (This year's entering nursing class had previously attended a total of 32 out-of-state colleges and universities and 13 in Georgia.)

I've told this before . . .

(Ed. note: The second in a series of human interest stories by our members and their families is presented this month under the continuing title, "I've told this before. . . ." In our November offering, "Psyched by a Pick-Up Boy," J. G. McDaniel, M.D., of Atlanta recalls one frustrating afternoon in dove season when he had to contend with more than his "tempermental" shooting. Contributions from other story tellers are welcome and should be mailed to the Journal of the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.)

Psyched by a Pick-Up Boy

EVERY SEPTEMBER Dr. Harold Harrison invites a large number of families down to his cattle farm in south Georgia. It is a most delightful affair—his mother prepares a big "sure enough, honest to goodness" country dinner which is served at high noon. Following that, those who like to swim or fish can do so in the lake. Hunters—men, women and children—are placed on stands in harvested grain fields where doves feed.

On this particular cloudless Saturday afternoon the sun was blazing hot, not a breath of air stirring. My two grown sons accompanied me, one stationed on each side. They are uniformly good shots, but I am a tempermental shooter, sometimes good, sometimes bad. If I try too hard, I always miss.

We were barely settled before the caps began to pop and the doves began to fly. I downed the first bird that I shot at, although it required two shots. This is always a good omen for me because I gain confidence. Pretty soon I had picked up six birds. This is hard work since when I down a bird, I always watch where it falls, then go to that spot and hurriedly pick it up; nothing else detracts my attention. Invariably while this is taking place, birds fly all over you—my sons kept yelling "Daddy, Daddy—over you!" All of this is occurring while you are trying to find a dead bird on the ground. Unfortunately, one's eyes will work just so fast and there is no way they can be speeded up.

After having picked up the six, I was completely bushed, wringing wet with sweat, and was seated on my shell case taking a rest. I was quite pleased with myself, however. My shooting had been pretty good and only an hour had passed.

About that time, Harold's overseer drove up in a pickup truck. He had three or four black boys in the back and asked me if I wanted a pick-up boy. This was like manna from heaven—of course I did! Then from the truck came running a nine or 10-year-old boy wearing the reddest shirt you ever saw. I asked him what his name was and he said, "Jeremiah, but they calls me Jerry."

He wanted to know how many doves I had and when I told him six he looked around and commenced to picking up empty shells. He commented, "Dey sure is a lot of empty shells." Then I explained to Jerry that his job was to sit up close behind me, look for doves, be perfectly still, and when I knocked a bird down, watch where he fell and not to take his eyes off that spot until he had run out and picked him up—and I meant run.

"You understand now?" "Yassa."

About five minutes later I saw a dove coming straight to me, my favorite shot. Behind me was a mumble, "17, 18, 19, 20." I said, "Now Jerry, quite counting those empty shells and be still and watch where this bird falls." I do not know

what happened behind me, but just as I pulled the trigger the bird veered and I shot again. Behind me, "mist him, mist him, mist him with both barrels, mist him with BOTH barrels."

This happened several times before I brought one down. I told Jerry to watch where he hit, then I turned the other way and downed another. I watched him fall, retrieved him, came back to find Jerry sitting on my shell box. I asked him if he found his bird. He replied, "Nawsir, I never did see him."

My shooting continued poor, but I took heart by making a good shot. The bird fell by a little bush not far away. Jerry saw this one, slowly walked out, but kept standing there. I asked him if he had found him—he said, "yassar, but he still live and he might peck me."

I gave Jeremiah a dollar bill and told him to go home. He said that he did not know the way home from there, then I pointed out the water truck and told him to run over and catch it. To my relief he was gone. He had already counted aloud over 50 empty shells, and I was tired of hearing him say, "mist him with both barrels."

My joy was short lived, however, because in about 10 minutes, Jerry was back. He said the man on the truck told him that he already was overloaded. He took up counting shells where he left off and remarked again, "You sure is shot a heap of times." I gave him another dollar and said very sternly, "Jeremiah, get out of my sight, I do not care where you go, just start walking." He pocketed his extra dollar, grinned, said "yassa" and left.

My shooting did not improve. I was hot and tired and even though I lacked one or two getting the limit, I went to a nearby vacant house, got under the shade of a chinaberry tree, and stripped to my waist.

Some 30 to 40 minutes later my sons came in, both wet with sweat but well pleased with themselves. One of them said, "Daddy, you didn't have such a good day, did you?"

Way out in the field I could see a little boy wearing a red shirt, playing happily with another boy. I replied, "No, I didn't."

J. G. McDaniel, M.D.



THE ASSOCIATION

NEW MEMBERS

Arnett, Thomas E. Thomas Area—Active— OBG	918 S. Broad Street Thomasville, Georgia 31792
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Gomez, Robert F. C. W. Long—Active— OTO	740 Prince Ave. Athens, Georgia 30601
Hamilton, Sandra D. C. W. Long—Active— Anes	165 Dunwoody Dr. Athens, Georgia 30601
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Longaker, Paul E. Bibb—Active—FP	Medical Center Macon, Georgia 31201
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Savdie, Solomon Y. MAA—Active—Su	2788 Bayard St. East Point, Georgia 30344
Smith, Robert W., III MAA—Active—I	478 Peachtree St., N.E. Atlanta, Georgia 30308

Souther, Joe C. Barrow—Active—FP	802 E. Broad St. Winder, Georgia 30680
Story, James L. Thomas Area—Active—Su	505 Gordon Ave. Thomasville, Georgia 31792
Strese, Fritz W. Thomas Area—Active —FP	Archbold Memorial Hospital Thomasville, Georgia 31792
Tekin, Mahir MAA—Active—Anes	3240 Jett Ferry Ct., N.E. Dunwoody, Georgia 30338
Tovar-de-Hoyos, Manuel South Ga.—Active—FP	2311 N. Patterson St. Valdosta, Georgia 31601
Ufema, John W. MAA—DE2—R	2666 Pangborn Rd. Decatur, Georgia 30033
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Williams, Donald D. Bibb—Active—EM	777 Hemlock Street Macon, Georgia 31201
Yodaiken, Ralph E. MAA—S—Path	1670 Clairmont Rd., N.E. Decatur, Ga. 30033
Yucel, Vehbi E. MAA—Active—PM	80 Butler Street, S.E. Atlanta, Georgia 30303

SOCIETIES

The October dinner meeting of the **Bibb County Medical Society**, held at the Idle Hour Country Club in Macon, featured as speaker member Edwin R. Watson, M.D., who with 37 other pediatricians from the United States, spent three weeks in August touring Russia, Hungary, Bulgaria and Roumania.

Eight members of the **DeKalb County Medical Society** were honored with plaques of appreciation by the county school system in August. Cited for 20 years service to the system as chairmen of the athletic committee were: T. O. Vinson, Joseph Tatum, F. G. Powell, Luther Vinton, Thomas Lowrey, Robert Shinall, Phillip Christopher and Albert Forgosie.

The **Georgia Medical Society** at its October meeting heard Dr. Robert Hargraves, adjunct associate professor of mathematics at Dartmouth College in New Hampshire discuss the application of computers to medicine.

Mrs. Howard S. Brown, safety chairman for the Auxiliary to the **Medical Association of Atlanta**, helped promote Fire Prevention Month (October) by

THE ASSOCIATION / Continued

alerting housewives to the danger of fires in the home and demonstrating lightweight ladders that make escape simpler.

PERSONALS

First District

Robert H. Carter of Savannah has been inducted as a new Fellow of the American College of Surgeons.

Third District

Cordele physician **O. T. Gower** was honored for 26 years as medical examiner for the Selective Service System in September ceremonies. Oscar Summers, chairman of the local draft board, presented a certificate signed by President Richard Nixon and Gov. Jimmy Carter to Dr. Gower during a Rotary Club meeting.

Fourth District

William R. Hardcastle of Chamblee is one of 1,675 physicians in the nation recently inducted into the American College of Surgeons.

Fifth District

Two Atlanta surgeons, **A. Cullen Richardson** and **James B. Lyon** of Emory University School of Medicine, were presented commemorative plaques October 18 in Chicago, Ill. for their work in authoring the film "A Clampless Technique of Abdominal Hysterectomy." The film premiered before the 10,000 members and guests attending the 59th annual Clinical Congress of the American College of Surgeons.

Atlanta physicians recently inducted as Fellows of the American College of Surgeons include: **Robert Crow**, **John A. Davidson**, **John H. Hartley, Jr.**, **Joseph R. B. Hutchinson**, **Thomas W. Marks**, **Clinton D. McCord**, **Walker C. McGraw**, **Mark S. O'Brien** and **Arnold Sweig**.

Sixth District

Rodney M. Browne and **G. Richard Jones** of Ma-

con and **Robert W. Oliver, Jr.**, of Dublin are new Fellows of the American College of Surgeons.

Seventh District

Paul L. Bradley of Dalton ended his term as president of the 300-member Georgia Surgical Society by presiding over the recent meeting of the organization at Sea Island, Georgia. **William C. McGarity** of Atlanta is his successor.

Benjamin H. Wofford, Jr. of Marietta and **Ban-nester L. Harbin, Jr.**, of Rome were inducted into the American College of Surgeons in cap-and-gown ceremonies October 18 in Chicago, Illinois.

Eighth District

Valdosta's **Fred C. Smith** and Waycross' **Roger A. Bates** are new members of the American College of Surgeons.

Ninth District

New Fellows of the American College of Surgeons from northeast Georgia include **Lawrence L. Durisch, Jr.**, Gainesville; **James W. Knowlton** and **Robert W. Slate** of Toccoa.

Tenth District

John R. Palmer, associate professor of Family Practice and chairman of the Physicians' Assistants Department of the Medical College of Georgia, talked about the purpose, training and medical responsibilities of this new group of workers in the health care field at Sea Island in September. He spoke before a joint meeting of the Southeastern Region of the American College of Physicians and the Georgia Society of Internal Medicine. He spoke on a similar topic for the 10th district Georgia State Nurses Association meeting in Augusta.

Robert G. Ellison, cardiac and thoracic surgeon, has become one of two holders of the newly created Charbonnier Professorships at the Medical College of Georgia. Dr. Ellison is a 1943 graduate of the Medical College and joined the faculty in 1947.

Paul G. McDonough of the MCG served as a visiting professor in obstetrics and gynecology at Johns Hopkins University School of Medicine in late September.

THE MONTH IN WASHINGTON

William I. Bauer, M.D., has resigned as director of the controversy-ridden Professional Standards Review Organization (PSRO) program, expressing dissatisfaction with the PSRO organization setup.

The surprise step-down was a shock to the top officials at HEW who have been reeling from the loss of other high officials upset over the lengthy reorganization of the health activities at the HEW department.

Charles Edwards, M.D., Assistant HEW Secretary for Health, interrupted a planned business retreat to hurry back to Washington when news of the resignation filtered out. He called a news conference but then cancelled it after the reporters had shown up. Dr. Edwards was in conference with HEW undersecretary **Frank Carlucci** at that time.

The PSRO program is a particularly sensitive one to

be subject to the inevitable repercussions and criticisms that follow a resignation. Members of the Senate Finance Committee have been taking a hard line on involvement of state medical societies in the PSRO review of institutional care under Medicare and Medicaid. Some physicians groups and state societies, and the PSRO advisory committee, have urged a broader authority for state societies. In general, HEW and Dr. Bauer had appeared to be attempting a middle course.

Furthermore, the gearing-up for the intricate and complicated program has been a mammoth task for Dr. Bauer.

The 48-year-old Dr. Bauer was named to the PSRO post last March after a career as a practicing internist in Greeley, Colo. Other HEW officials who have resigned in the past several months are **Gordon McLeod**,

M.D., director of the Health Maintenance Organization (HMO) program, and Arthur Lesser, M.D., head of Maternal and Child Health Services.

Statement of Complaints

In a statement, Dr. Bauer said the administration has made a "significant commitment to PSRO but that commitment has not been translated into action. . . ."

"This extremely complex program with ramifications at all levels of medical care has been provided with limited resources and those resources that were made available could not be effectively administered and utilized because of the organizational structure," Dr. Bauer said.

According to an HEW spokesman, the resignation stemmed from a dispute between Drs. Bauer and Edwards over organizational control of the PSRO program. Dr. Bauer was said to believe that he could not exert meaningful authority under the present setup in which much of the field work for PSRO, involving hundreds of physicians, would not come under his line control but under the Bureau of Quality Assurance. Dr. Edwards, the spokesman said, contended that Dr. Bauer would still have the say-so, but Dr. Bauer obviously disagreed.

Underlying the dispute, apparently, has been the effort of Dr. Edwards to pry PSRO control away from Social Security and Social and Rehabilitation Services, present overseers of Medicare and Medicaid, and to give the Health Department clear jurisdiction in PSRO.

Under the reorganization, 50 physicians at Social Security and 150 in the Health Services Administration are assigned to PSRO but not directly under Dr. Bauer who had 36 staff positions.

There was no indication from Dr. Bauer of any philosophical differences with the administration over how PSRO would function at the local and state level.

House Approves HMO's

The House has approved legislation that will provide federal funds to start a limited number of experimental Health Maintenance Organizations over a five year period to the tune of \$240 million. The Senate's version of HMOs, passed months ago, would provide \$805 million over the same period. House and Senate conferees must now resolve the differences.

The compromise bill voted by the House calls for spending \$60 million this fiscal year, the Administration figure. The bill meets many objections raised to the original measure by the Administration and the American Medical Association.

Though no specific number limitations was set in the House bill, the limit of authorizations to \$240 million will provide an effective ceiling on the number of HMO's which could be established. The House Commerce Committee estimated the legislation would be used to bring to the operating stage approximately 100 new HMO's.

The bill has a flat five-year cut-off for the HMO program.

Unlike the Senate bill, the House legislation does not pre-empt state laws that restrict formation of HMO's. The reason given by the House Commerce Committee was "the rapid change already underway in state legislation designed to remove these barriers." Approximately 20 states have already adopted legislation specifically authorizing HMO's.

The bill limits grants or contracts for planning and

initial development costs by prohibiting this assistance after 1976.

Initial development assistance would be prohibited after 1977.

Loans and loan guarantees for initial operation costs are authorized except that loan guarantees could be provided only if the HMO will serve residents of a medically underserved area.

The bill has no authority for loan guarantees for construction projects.

For grants and contracts for feasibility studies, initial planning and initial development costs, the bill would authorize \$40 million for fiscal year 1974, \$45 million for fiscal year 1975, and \$50 million for fiscal year 1976. In addition, it would authorize \$55 million for fiscal year 1977 for grants and contracts for initial development costs. The bill would authorize \$20 million for fiscal year 1974 and \$30 million for fiscal year 1975 to be appropriated to the loan fund.

The bill, unlike the original subcommittee bill, has no authority for demonstration grants and contracts for enrollment of the indigent, for providing service in rural medically underserved areas, and for enrollment of high risk individuals. There also is no authority for special project grants and contracts, for grants for HMO management training, and for program evaluation.

Provisions for protection against insolvency of HMO's, against the cost of providing unusual amounts of health services or of providing out of area health services, and protection against unusual losses were not contained in the final bill. Also deleted were provisions which authorized technical assistance and consultative services to aid in the planning or development of an HMO.

Presidential Quote

Below is an interesting quote found in *Presidential Documents*:

Richard Nixon 1973, Vol. 9, #36, page 1063 and 1064.

THE PRESIDENT: One of our major problems, incidentally, I might say, is, as you were just talking about the Trade Bill, Wilbur Mills' incapacity. I don't know whether you know he has just had an operation, a disc operation, which, incidentally, if he had asked me, I would have told him never to have it. I haven't had one but I have never known one that was successful.

Informing the Public

A public-private National Center for Health Education to oversee efforts to provide better health information to the public was recommended by President Nixon's Special Committee on Health Education.

In a report to the chief executive, the 17-member advisory group said future improvements in health care delivery and financing "will be virtually nullified unless there is, at the same time, an improvement in health education, which means not just supplying information about health to people, but motivating them to accept the information and put it to work in their daily lives."

Only a small fraction of the nation's health dollar is spent on public education, the report said, declaring there is a vital need for innovation and experimentation with new kinds of educational programs.

MONTH IN WASHINGTON / Continued

The National Center for Health Education would be a private, nonprofit organization authorized by Congress and financed from U. S. and private funds at an estimated yearly cost of about \$3 million. The Center would be managed by a 25-member board of directors appointed by the President and confirmed by the Senate. It would conduct research, coordinate state and local and national public education programs, and serve as an information clearing house.

Chairman of the advisory committee, which spent two years on the report, is R. Heath Larry, vice chairman of U. S. Steel. There were two outright dissents on the report's findings and eight additional views which included expressions of reservations about the report.

In addition to the National Center, the President's Committee recommended:

- An HEW office serve as focal point for government-wide health education efforts.
- Consumers be more adequately informed about the health value of products and services.
- Hospitals provide patient education programs.
- Model state health education laws.
- Business, labor be encouraged to undertake comprehensive health education programs.
- Community health education centers be established.
- Serious consideration be given to preparing selected non-professional health educators as "paramedics, in effect, in the field of health education."

Joseph Beirne, president of the communications workers (AFL-CIO), said the proposed center wouldn't work and that a firm commitment to the goals of health education is needed from four groups that would be the key to success: American Medical Association, American Hospital Association, American Public Health Association, and American Dental Association.

The other dissenter was Joy Cauffman, Ph.D., University of Southern California School of Medicine, who said the report discriminates against the coalition of national health organizations.

J. Henry Smith, president of the Equitable Life Assurance Society, said he was "uneasy" about the report's lack of clarification on how the Center would be set up and the "somewhat cursory" recommendations in other areas. Charles A. Stegfried, vice chairman of Metropolitan Life Insurance Company, said "numerous recommendations are made for extensive new activities without any clear indication of just what they might accomplish, what they would likely cost, or whether the hoped-for improvements would be commensurate with the cost."

Medical Veto Stands

President Nixon has won a showdown with Congress on health spending. The House failed to override his

veto of the emergency medical services bill, making the veto stand and bolstering the administration's hopes of curbing federal spending this year.

The Senate voted before the August recess to overturn the veto.

In the interval, pro-Administration and anti-Administration forces and supporters of the bill worked hard to line up House votes for their sides in what was regarded as an important test of the President's powers.

The bill authorized \$185 million over three years to aid state and local governments set up emergency medical services to cope with auto crashes and the like. In his veto message, President Nixon said the measure would establish "a large new federal program in an area which is traditionally a concern of state and local governments."

The chief executive also criticized a rider to the bill ordering the continued operation of eight public health service hospitals. He said "their inpatient facilities have now outlived their usefulness to the federal government."

Despite the Administration's opposition, the bill sailed through Congress by overwhelming votes.

The House vote on the veto was viewed as a key battle in the legislative war pitting congressional Democrats against the Administration, a fight not only involving the issue of economy in government but the powers of Congress and the powers of the executive branch.

President Nixon had been successful in four previous vetoes this year.

Labor and National Insurance

Labor's leading proponent of a sweeping National Health Insurance bill, Leonard Woodcock of the United Autoworkers, engineered a tentative agreement with the Chrysler Corporation requiring the company to pay the full workers' tab for any National Health Insurance plan that comes down the pike.

It was believed to be the first such provision in a major labor settlement and made clear labor leaders' desire to have management shoulder the full cost of NHI. The agreement made dollars and sense from the standpoint of the UAW, but took some of the gloss off the repeated Woodcock assertions before congressional committees that workers are willing to pay their fair share of any national health program.

Steven Schlossberg, UAW's general counsel, was quoted as saying that autoworkers have always supported NHI but "now they have even more incentive to press for its passage since, because of the new contract, there is no economic incentive for them to be against it."

The agreement states that in the event a National Health Insurance program is enacted Chrysler will be required to pay any direct premium or taxes which may be levied on workers.

JOURNAL
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DECEMBER / 1973

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Weight-dose chart:

WEIGHT (lb)	EACH DOSE (g)	TABLETS
25	0.25	1/2
50	0.5	1
75	0.75	1 1/2
100	1.0	2
125	1.25	2 1/2
150 & over	1.5	3

The regimen for each indication follows:

INDICATION	REGIMEN	COMMENTS
Pinworm disease	Two doses per day for 1 day. Repeat in 7 days. This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



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Cover

A child's delight at Christmas—a feeling most of us wish we could recapture. Design by Atlanta artist Bob Hamill.

The author explores the "characteristics" of those applying for certification as physicians' assistants and explains the guidelines under which they must operate.

Physicians' Assistants Update—Fall 1973

JOHN RHODES HAVERTY, M.D., *Atlanta**

AN EDITORIAL APPEARED in the September 1972 issue of the *Journal of the Medical Association of Georgia* entitled "Physicians' Assistants in Georgia." That paper concerned the situation at that time regarding physicians' assistants in our state, particularly as it related to definitions, legislation, proposed testing procedures for physicians' assistants, and some preliminary remarks regarding accreditation and certification. I would refer you to that article as a background for this particular paper. It is hoped that this article will further clarify issues related to the certification of physicians' assistants in Georgia, to update activities that have taken place by the Composite Board of Medical Examiners related to these health workers, and to give some statistical details regarding those physicians' assistants who have been certified to the present time.

In the editorial noted above, it was stated, "Presently it is the intent to accept for application all graduates of the previous ongoing and/or planned physicians' assistants programs at Emory University School of Medicine, the Medical College of Georgia, and Georgia State University, without additional testing of the proposed physician's assistant. All other applications will involve both written and practical examinations of the proposed physician's assistant."

Acceptance Extended

Since this was written, the Composite State Board of Medical Examiners has extended its acceptance of applications to all graduates of the above-mentioned physicians' assistants programs, and in addition to all graduates from AMA approved pro-

grams which train individuals who will become assistants to primary care physicians. Presently this comprises some 20 approved institutional programs.

Because of problems inherent in creating valid written and oral testing for such individuals, no such tests have been devised in Georgia. The National Board of Medical Examiners, in cooperation with the American Medical Association, has created such certifying examinations, and the first such testing was to take place in centers around the United States (including Atlanta and Augusta) on Wednesday, December 12, 1973. This test was open only to those persons who have graduated or will have graduated by January 31, 1974, from a program approved by the AMA Council on Medical Education for training assistants to the primary care physician. In addition to the above, persons also were eligible who were to have graduated by the above date from a program training assistants to the primary care physician which has been funded by the Bureau of Health Manpower Education, or graduates from a program of at least four months duration within a nationally accredited school of medicine or nursing that trains pediatric or family nurse practitioners. The deadline date for the receipt of applications for this certifying examination was October 10, 1973, upon payment of a fee of \$55.00 to the National Board of Medical Examiners.

Study and Experience

Because of the difficulties in the creation of a valid test at the state level, and because of the restrictions placed upon the initial takers of the national examination, the Composite Board of Medical Examiners included in January 1973 the following additional regulations for individuals to be

* Dean of the School of Allied Health Sciences, Georgia State University in Atlanta.

considered for certification in Georgia. "Graduation from a physician's assistant program of study approved by the Board, or satisfactory completion of a formal course of study in the health field combined with actual work experience related to the program of study such that the total time of these two segments would cover at least four years, provided that the combined study and experience of such applicant is consistent with the job description contained in the application." At the same time, the Board approved the following: "The Board is authorized to issue a temporary certification to those applicants who have satisfactorily completed the requirements set down by the Composite State Board of Medical Examiners and have been approved by the Evaluation Agency. This temporary certification shall have the same force and effect as a permanent certification until such time as the first examination for certification is given." Thus, applicants in Georgia may be considered by the Evaluation Agency and the Composite State Board of Medical Examiners upon satisfactory completion of an AMA approved program for assistants to the primary care physician, or upon satisfactory completion of any formal course of study in the health field (whether civilian or military) combined with work experience in this field such that the total time equals at least four years, and in addition that the job description supplied by the physician employer is related to the formal course of study in the health field and the experience gained thereafter.

From the beginning of the receipt of applications by the Composite Board in late 1972 through August of 1973, a total of 78 applications had been received (See Table 1). Of these 78, 30 applications have been approved, 14 have been disapproved, 23 were pending the October, 1973, meeting of the Board, and 11 applications were incomplete and were returned for various reasons. Reviewing the pending applications, the approximate ratio of 2/3 of those completed applications finally being approved would seem to hold up, and thus it seems likely by the time this article is published there will be 40 to 50 practicing physicians' assistants within our state.

TABLE 1	
P.A. APPLICATIONS RECEIVED THROUGH AUGUST, 1973	
Approved	30
Disapproved	14
Pending	23
Incomplete (returned)	11
Total	78

Using the first 44 physician's assistant applications acted on (whether approved or disapproved by the Board), some characteristics of these individuals are interesting, and presented in Table 2. No significant differences of these characteristics between those approved and those disapproved are evident.

TABLE 2	
CHARACTERISTICS OF FIRST 44 APPLICANTS ACTED ON (APPROVED OR DISAPPROVED)	
	Per Cent
Men	80
Women	20
White	95
Black	5
Rural	62
Urban	38
Less than 25 years old	7
25-35 years old	55
35-45 years old	27
More than 45 years old	11
Ex-Service Corpsmen (Navy 21%, Air Force 47%, Army 31%)	43
Nurses (RN 75%, LPN 25%)	27
Allied Health Personnel (civilian)	25

It should be obvious from Table 2 that the large majority of those applying P.A.'s are white men, and that over 3/4 of them are from rural areas and will be practicing with physicians in rural areas. Over 4/5 are between the ages of 25 and 45. More than 2/3 are ex-service corpsmen. Interestingly enough, more than 1/4 are nurses, and another 1/4 have been civilian allied health personnel.

Table 3 lists the educational programs completed satisfactorily by those P.A. applications which have been acted on to date. This table does show some differences between those in the approved group, and those applications which have been disapproved. It is obvious that the "other" category predominates

TABLE 3		
EDUCATIONAL PROGRAMS COMPLETED SATISFACTORILY BY P.A. APPLICANTS ACTED ON		
	Per Cent	
1) "Type A" P.A. programs	11	
2) Other civilian P.A. programs	30	
3) Service programs only	16	
4) RN schools	20	
5) Other	23	
	Approved Applications (Per Cent)	Disapproved Applications (Per Cent)
1) "Type A" P.A. programs	13	7
2) Other civilian P.A. programs	43	0
3) Service programs only	13	21
4) RN schools	17	29
5) Other	13	43

in the group of disapprovals, and that nursing graduates appear to be significantly larger also in the disapproved group.

Looking at the data from Table 3 in another way, 94 percent of the applicants applying who have graduated from a physician's assistant program of any kind were approved, while only 50 percent of graduates from nursing schools, service schools, and other types of graduates were approved. If these statistics hold up for future applications, it is obvious that individuals who wish to pursue a career as physicians' assistants have a much greater likelihood of being certified in Georgia if they graduate from a formal program which trains physicians' assistants, even though it is possible for them to become certified otherwise.

Table 4 presents the statistics of the types of medical practice engaged in by the employing physicians of those P.A. applications which have been acted on. Almost 2/3 of the physicians are what might be called primary care physicians, including family practitioners, internists, and pediatricians.

Table 5 indicates briefly the usual reasons for disapproval of an application. The predominant reason being that no formal educational program has been completed by the applying individual. Unless the Board regulations are changed, or unless the eligibility requirements for taking the examinations which will be given periodically are broadened, it is unlikely that any of these individuals in this category will become eligible for certification as a P.A. in Georgia.

Those listed in the second category of reasons for disapproval would be expected to qualify as time passes, assuming that their continued work will be in the field in which they wish to be certified. Those individuals listed in the third category may well be certifiable provided the physician is willing to limit the activities outlined in the submitted job description.

Table 6 outlines some typical job descriptions which have been approved by the Composite Board. It should be realized that these are summary notations, and the approval or disapproval thereof depends to a large measure on the type and the extent of the educational program, as well as the type of previous health delivery experience by the applying P.A. Also, on the application form itself, details and specific limitations for each of these items usually are spelled out.

From the standpoint of the Evaluation Agency and of the Composite Board of Medical Examiners, the job description is the most important evaluative tool used in deciding whether an applicant should be approved or not. The relationship between the job description and the *provable* and *documented*

TABLE 4
EMPLOYING M.D. TYPE OF PRACTICE FOR
P.A. APPLICANTS ACTED ON

	Per Cent
Family Practitioners	43
Internists	18
Surgeons	18
Anesthesiologists	11
Pediatricians	2
Allergists	2
Psychiatrists	2
Ophthalmologists	2

TABLE 5
USUAL REASONS FOR DISAPPROVAL
FOR P.A. APPLICATION

	Per Cent
No formal educational program completed	42
Less than four years total of education-experience	29
Job description too broad	29

TABLE 6
TYPICAL JOB DESCRIPTIONS APPROVED

Complete history
Complete or partial physical examination
Performing cardio-pulmonary resuscitation
Anesthesia care of patients
Writing orders or prescriptions, countersigned by the physician
Admissions to hospitals, but not discharges
Counselling patients and families
Routine pediatric office care
Home visits
Making rounds in hospitals, with or without the physician
Assisting at surgery
Telephone advice
Supervising other office personnel
Maintaining office and hospital charts
Various laboratory tests, diagnostic procedures, minor surgery, cast applications, intravenous infusions

previous education and experience is the most important criterion in deciding whether to certify the prospective physician's assistant, or to disapprove the application. Thus the construction of the job description by the applying physician should be made carefully, with constant attention to the background of the proposed physician's assistant. Broad statements, allowing almost unlimited activities are seldom approved. Detailed comments providing for activities which clearly have not been a part of the educational program of the P.A. also are reasons for disapproval. For example, although histories and physicals are the most common items listed in job descriptions, it is quite clear that the graduate from

the average nursing school in Georgia has not had such experience, since physical examinations and complete medical histories have not been taught to these students until very recently.

In addition to the job descriptions, some problems have come up that make it useful for the physician to review the application prior to forwarding it on to the Composite Board of Medical Examiners. Item 14, "Work Experience Related to Medical Field," frequently is helpful in proving the experience of the applying P.A., and thus may be utilized sometimes in expanding the degree of activity allowable in the job description. It should be recognized, however, that any work experience noted in this item which has not been under the direct control of the applying physician, should be documented by the institution or individual who supervised the applying P.A.

One Employing Physician

In item 8, "Physician's Name," and in the narrative portion of the job description, it should be remembered that the law allows only a single employing physician, although in item 18 on the application form, names and addresses of other physicians who will serve as alternate supervisors may be listed. Nevertheless, several applications have had to be returned because more than one physician's name



Physicians' assistant students from Emory University spend their first year in the classroom, the second in clinical situation at Grady Memorial Hospital. Steve Ruggles, 27, ex-Navy corpsman with a degree from Ohio University, learns to give a physical examination, typically found on P.A. job descriptions. He hopes to work in Georgia or Florida and says most P.A.'s are interested in rural areas.

was placed as *the* employing physician. A new regulation of the Board requires that the employing physician sign each page of the job description.

One problem already arising concerns the termination of employment by physicians' assistants from their original physician. Should the individual choose to resign from the employ of one physician, and go to work as another physician's P.A., a process of recertification is necessary under the laws of Georgia. This recertification must include certain basic data such as the P.A.'s address, etc., and the new employing physician's name, address, medical education, type of practice, etc. It also must include an entirely new job description presented by the new employing physician. The same caveats apply to this job description as mentioned above, particularly if it differs at all from the previous one submitted to the Board.

Some P.A.'s have become certified in Georgia and then have resigned and moved out of the State, presumably with the intent to become physicians' assistants elsewhere, perhaps through a mechanism of reciprocity. No such mechanism has been developed as yet in this state, either for allowing previously certified P.A.'s from other states to become certified in Georgia, nor for assuring any other state of the competency of those P.A.'s certified here to practice elsewhere. These items obviously will have to be addressed by the Board in the future, and may in fact require additional regulations or legislation.

Some general comments related to the work activities of P.A.'s may be of value. The AMA has some help in these matters. The AHA, with concurrence by the AMA Council on Health Manpower, states, "A determination of the specific tasks such an individual is authorized to perform in the hospital must be made pursuant to a professional review by the medical staff . . ." and again, "When a person having the qualifications of a physician's assistant is employed by a hospital, he is not then acting in the role of a physician's assistant." Further, "The Board of Trustees [of the AMA] and its Council on Health Manpower recommend that it be the policy of the American Medical Association that a physician's assistant not function in that capacity when an employee of and paid by a hospital or by a full-time salaried hospital-based physician." These are AMA guidelines, and are not part of the P.A. law in Georgia, but can be used in helping physicians and medical staffs of hospitals decide the limitations to be placed on P.A.'s in their communities. It should be quite clear that a physician using a physician's assistant in his own private practice whether in clinic, office, or home visits, may determine, within the bounds of the law and the approval of the Composite Board of Medical Examiners, those activities for which he will be responsible. On the oth-

er hand, those activities of a P.A. in a hospital setting, whether employed by a full-time hospital-based physician or an attending physician, should be approved by the entire medical staff.

Reimbursement for Activities

As far as reimbursement for activities of P.A.'s is concerned, current policies of third party payors, both governmental and voluntary, impose no restrictions on reimbursing the physician for services provided by his P.A. when the physician is physically on the premises where care is provided. However, under the Medicare program, those services performed by non-physician personnel outside the physician's office are not reimbursable unless the attending physician is physically present at the time. Furthermore, it is stated policy of the AMA that a salaried employee of a physician does not bill for his or her services, nor does the physician employer bill separately for the services performed by his employees.

It is important that the P.A. be introduced and identified constantly as to his role in the delivery of health care services to all patients for whom he may provide services, and that the physician not delegate any patient care to such an assistant when the patient indicates an unwillingness to be served by the P.A. This includes, of course, the use of a P.A. as a surgical assistant, as well as in all other roles performed by him.

At the latest AMA House of Delegates meeting in New York in June, the House reaffirmed and expanded its statements on the status and utilization of new health professionals in hospitals. This Report G of the Board of Trustees says in part:

"As authorized by the medical staff, they [P.A.'s] function in a newly expanded medical support role to the physician in the provision of patient care.

"They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care.

"They make entries on patients' records, including progress note forms, only to the extent established by the medical staff."

This report goes on to state that:

"The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws:



Viola Harrell, 22, was working in an intensive care unit following graduation as a registered nurse from Georgia Baptist School of Nursing, when she decided she wanted to learn more and do more in the health care field. Now as a student-P.A., she spends an hour at the end of her day at Grady with physicians such as Jim Cameron (L), reviewing patient cases.

- A. Application for use of such professionals by medical staff members must be processed through the Credentials Committee or other medical staff channels in the same manner as for medical staff membership and privileges.
- B. The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant."

Graduates from our own state are beginning to function as physicians' assistants. From Emory University School of Medicine, graduates from the medical specialty assistants program already have been approved in some areas, largely in the field of anesthesia. Graduates from Georgia State University's pediatric assistants program have been certified to practice with pediatrician employers. There have been no graduates from the Medical College of Georgia's program to date, although they are expected during 1974. Emory University will graduate its first students from its physicians associate (primary care physicians' assistants) program in December, 1973. No other P.A. programs are known in Georgia at this time.

Impact Increases

It is obvious that P.A.'s are beginning to make an impact in our state. It is also obvious that this will

P.A. / Haverty

increase, both as to the numbers of individuals employed, as well as the degree to which these new health workers are utilized in the delivery of health care services. As stated in my article last year, "Undoubtedly, difficulties will arise. Confusion does and will continue to exist in many areas related to this subject." This prediction still applies. It is quite likely that new regulations and perhaps new legislation will have to take place to solve some of the unforeseen problems that have and will arise. We can profit by the experiences of other states, and your Composite Board of Medical Examiners as well as

your Medical Association committees are keeping abreast of developments in the field. It is hoped that this article will be of some value to you concerning this subject, and will be useful in making your own decisions on the role that these new individuals can play in your practice. I and the other officers of the Medical Association of Georgia and its staff, as well as the members of the Composite Board of Medical Examiners and the staff of the Joint Secretary stand ready to help you in any way that we can. Please feel free to call upon us at your convenience.

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MAGNET '73

PHYSICIANS' ASSISTANTS, representatives of the Georgia Hospital Association and guests from the Medical Association of the State of Alabama joined with over 100 Medical Association of Georgia members in the MAGNET '73 program November 3-4 in Atlanta.

The major thrust for the conference, held at the new Atlanta International Hotel, was communicating medicine's story. The list of distinguished speakers included U.S. Congressman Tim Lee Carter (R-Ky.); Frank Campion, communications director of the American Medical Association; and Reg Murphy, editor of the *Atlanta Constitution*.

Attendees also were brought up to date on current AMA activities by E. B. Howard, M.D., executive vice president. Dr. Howard discussed Phase IV restrictions,



Carter



Howard

health maintenance organizations, the value of the fee for service billing system and national health insurance. Dr. Howard predicted that national health insurance legislation probably would not pass in any form in the near future due to the large number of bills now before the Congress and the complexities of financing the program.

Dr. Howard said "There will be an HMO bill reported out" but he was of the opinion that the President would veto it regardless of content.

The Sunday portion of the MAGNET Conference was devoted to debate and panel discussion about Professional Standards Review Organizations (PSRO) and their impact on the public and the private practice of medicine.

John P. Heard, M.D., president of the DeKalb County Medical Society debated "What the Public Should Know About PSRO" with Robert B. Hunter, M.D., a member of the National PSRO Advisory Council. Later Dr. Heard and Dr. Hunter were joined by Dr. E. B. Howard for a panel discussion on PSRO with lively audience participation.



Heard



Campion

There are many tangible and intangible reasons for seeking accreditation of an educational program and the entire process is now under local control.

Accrediting Continuing Medical Education Programs in Georgia

NICHOLAS E. DAVIES, M.D., *Atlanta**

TO PARAPHRASE PRESIDENT LINCOLN, the physicians of Georgia will little note, nor long remember what occurred in Atlanta on September 14, 1973, but with the support of those people who are concerned with quality health care, it should be the beginning of a new era.

On September 14, 1973, the Continuing Medical Education Program of Piedmont Hospital, Atlanta, was accredited for a period of two years by the newly organized Accreditation Subcommittee of the Medical Association of Georgia's Task Force on Continuing Medical Education. This subcommittee is composed of Lamar S. McGinnis, Jr., M.D., Decatur, chairman; James L. Achord, M.D., Macon; O. Wytch Stubbs, Jr., M.D., Chamblee; and Charles Underwood, M.D., Marietta. The American Medical Association had as its representatives Rutledge W. Howard, M.D., associate director of AMA's Department of Medical Education, in Chicago; and J. Rhodes Haverty, M.D., Dean of Allied Health Sciences for Georgia State University in Atlanta, and president-elect of the Medical Association of Georgia. The Medical Association of Georgia's staff representative was Adam R. Jablonowski.

Background Nationwide

In order to appreciate the significance of this event, some background information should be known. Since its founding in 1847, the AMA has concerned itself with medical education. The Flexner Report in 1910 was of prime importance in setting high standards for undergraduate medical education. Since that time, medical schools have been accredited by a Liaison Committee on Medical Education composed of representatives from the AMA and from the American Association of Medical Colleges (AAMC).

Several decades after the Flexner Report, the

AMA initiated the formation of a group to supervise and regulate postgraduate programs for physicians. This group, called the Liaison Committee on Graduate Medical Education, is composed of representatives from the AMA, the AAMC, the American Hospital Association, the Coordinating Committee of Medical Specialties, and the Association of Boards of Medical Specialties. It now approves internship, residency, and fellowship programs.

It became obvious in the 1960's that much of the newest medical information was not reaching the people who needed it the most, the practicing physicians. In 1964, the AMA began a concerted effort to promote continued education for practitioners. In order to be sure that it was recommending quality educational programs, the AMA undertook to evaluate the programs that it had promoted. For in this reason, in 1966 the accreditation of institutions that offered continuing medical education (CME) programs was begun. The AMA has now certified over 250 institutions who have applied to them and who have met their standards. These programs are generally national in scope since they are directed toward regional or national attendance. The two institutions in Georgia who have applied to and been accredited by the AMA are the Department of Continuing Medical Education of the Medical College of Georgia, headed by Dr. Glenn Garrison, and the continuing medical education program at the Center for Disease Control in Atlanta, headed by Dr. Alfonso Holquin.

Experience in Georgia

Most medical educators agree that physicians learn best from their own experiences, and that local educational programs have the greatest direct effect on patient care. For this reason the AMA has encouraged state and local medical societies to upgrade the educational opportunities on the local level. One way to do this, but certainly not the only

*Practicing Atlanta internist and chairman of the Committee on Education of the Medical Association of Georgia.

one, is to recognize those institutions which have excellent local programs and to encourage those whose programs are less than excellent to improve them. Toward this end, the AMA proposed to state medical societies that if the states would form their own accreditation programs and if they met the AMA's standards, then the AMA would accept the accreditations of the state societies as their own, putting them on an equal footing. In essence, this would mean that should the continuing medical education program at any hospital be accredited, in the eyes of the AMA, attending the weekly conference for an hour would be equivalent in educational value to attending an hour of lectures at, for example, the American Heart Association meeting in Dallas, or the American College of Surgeons meeting in Acapulco. A parallel to this position would be for the AMA, through the Liaison Committee on Medical Education, to say that all medical schools have met certain basic standards and that each is capable of producing fully qualified physicians, regardless of the size, location, or endowment of the school.

Two years ago the House of Delegates of the Medical Association of Georgia accepted the principle of accreditation of continuing medical education courses. Through the efforts of many physicians in Georgia, the Council of Medical Education of the AMA on June 22, 1973, provisionally approved the Medical Association of Georgia's continuing medical education accreditation program for a period of one year. The accreditation program will be re-evaluated by the AMA next April and should it prove to be satisfactory, it will be approved for an additional three year period.

Scope

Georgia is the thirteenth state medical society to institute an accreditation program for local educational institutions.* Our accreditation program will be directed primarily toward community hospital's educational activities. We shall also encourage accreditation for medical programs which are not national in scope, such as scientific sessions at local medical societies; for local units of voluntary health organizations not under national administration for their continuing medical education; and for other local organizations and institutions such as medical assemblies, public health conferences, etc.

* The thirteen states are Arizona, California, Connecticut, District of Columbia, Georgia, Illinois, Indiana, Maryland, New Jersey, New Mexico, Pennsylvania, Tennessee, and West Virginia.

The tangible reasons for seeking accreditation of an educational program are less compelling than the intangible reasons. When a program is accredited, it is listed in the issue of the *Journal of the American Medical Association* that describes educational opportunities for the coming year. Because of the accreditation, the educational hours are automatically acceptable for Category I credit toward the Physicians Recognition Award of the AMA. An AMA accredited program is not, however, automatically accepted by the American Academy of Family Practice. The Georgia CME Committee hopes that in the future the American Academy of Family Practice will work closely with it because, since our standards shall be kept high, committee members feel that our approved program should be acceptable to the AAFP.

The intangible reasons for seeking accreditation are numerous. An accreditation survey is, in a sense, an education consultation. It is an opportunity to have interested practitioners and directors of medical education at community hospitals to evaluate an educational program, find its strengths and weaknesses, and offer constructive criticism. Because all of this is done voluntarily, there is no feeling of compulsion by the institution being surveyed or by the surveying team. In time, the accrediting body in Georgia will reach a degree of sophistication as to methods, educational resources, the use of audit to determine educational needs, and other related topics, so that it will be of great value to a community hospital to receive its advice. Indeed, it is hoped that all continuing medical education programs within the state will, in time, band loosely together in order to increase their value to the practicing physicians.

How to Proceed

The Accreditation Subcommittee has been asked to survey several more programs during the next few months. Applications for accreditation of any continuing medical education program in Georgia are now being accepted. They should be directed to the attention of Mr. Adam Jablonowski at the Medical Association of Georgia headquarters. There are now 43 hospitals in the state of Georgia with over 100 beds. We would hope that during the next few years most of these hospitals will ask to have their educational programs evaluated by a group of their peers. They will not be compelled to. We look upon this as another means by which physicians in Georgia can continue to seek excellence.

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Intracranial Isolation of the Canine Circle of Willis

CARROLL OSGOOD, M.D., MICHAEL FLEMING, M.D. and JOSEPH WILLIAMS, M.D.,
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CLINICAL INTEREST IN MICROVASCULAR neurosurgery is increasing, and it would appear desirable to design a reliable, intracranial canine stroke model. Subsequently, microvascular grafting procedures could be superimposed on this stroke model to test their efficacy.

White⁸ in 1937 decerebrated dogs by ligating the basilar artery at midpontine level (above sixth nerve and anterior inferior cerebellar artery), and dividing all branches of the common carotid system bilaterally, up to the angle of the jaw. However, this involves a difficult, extensive neck dissection, often with damage to the numerous laryngeal nerve groups. The dog has very extensive extracranial arterial anastomoses, but only three large arteries actually feed directly into the Circle of Willis, namely two internal carotid arteries (of about 1 mm diameter), and the larger basilar (about 1.2 mm).

We reasoned that if these three vessels were occluded at their entrance into the Circle of Willis, cerebral ischemia and a "stroke" would result. However, there are two smaller vessels on each side, the ophthalmic and ethmoidal, of .2 mm size, which join the proximal anterior cerebral artery just beyond its takeoff from internal carotid, lateral to the optic chiasm (see Figure 1). Although the dog brain weighs 75 gm. and has a per minute circulation of 65 cc, these small ophthalmic and ethmoidal arteries are capable of maintaining cerebral blood flow if both internal carotids and basilar are occluded, either acutely or serially.

Materials and Methods

Seven mongrel dogs were selected, weighing from 15 to 30 kg (male and female). The dogs were anesthetized with intravenous pentobarbital sodium (25 mg/kg), and an endotracheal tube inserted. Each animal was given 8 mg Decadron and 50 cc of 50 per cent Mannitol intravenously after intubation, and placed supine, with the head tilted to 30

degrees to the left and elevated 15 degrees. A femoral artery catheter for constant arterial pressure monitoring was installed, and animals that became significantly hypotensive (systolic less than 50 mm Hg) for 15 minutes or longer during the procedure were excluded.

A right craniotomy was performed via a vertical three inch incision and the temporal muscle split to expose the temporal calvarium. A 2 by 2 cm temporal craniectomy was extended as far as a point three mm medial to and beneath the fifth nerve, which is

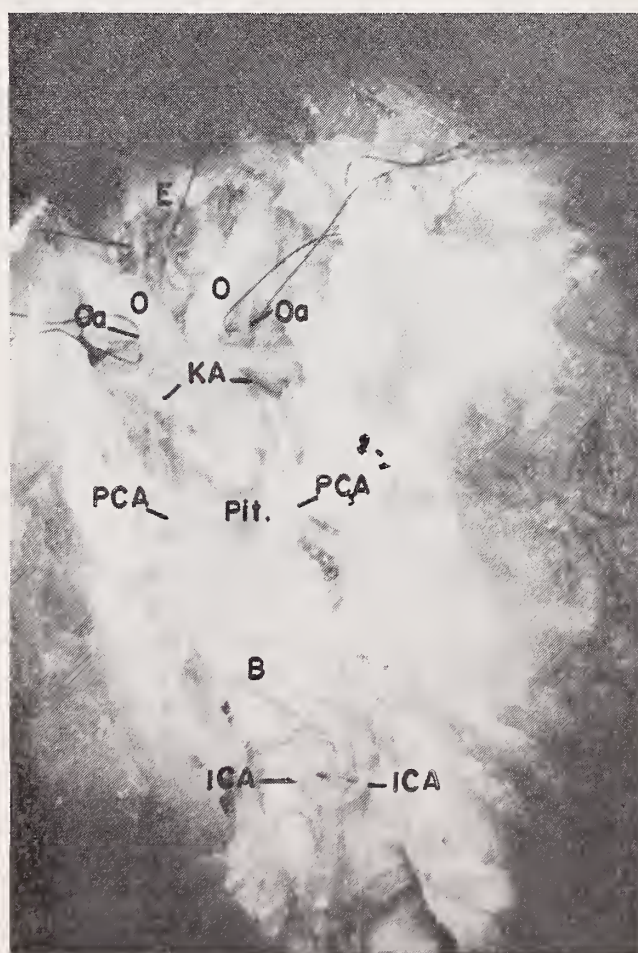


FIGURE 1

Key to abbreviations: E—Paired ethmoidal arteries; O—Optic nerves; Oa—Ophthalmic arteries joining anterior cerebral on each side; KA—Clip on each internal carotid; PCA—Posterior communicating artery on each side; Pit—Pituitary gland; B—Basilar artery on pons; ICA—Inferior cerebellar artery. Note clip on basilar just above their take-offs.

* Presented at the scientific meeting of the Georgia Neurosurgical Society May 13, 1973 during the 119th Annual Session of the Medical Association of Georgia in Augusta. Work on the paper was completed by Drs. Osgood, Fleming, and Williams at the Neurosurgical Research Laboratory, Veterans Administration Hospital in Atlanta. All were associated with Emory University School of Medicine's Department of Neurosurgery.

extradural at this point, and easily identified with the operating microscope at 6 \times . This insures removal (curettage) of the thin bony partition between the pituitary area and middle fossa, and will permit retraction of the tentorial edge later.

The middle fossa dura is then opened with a medially curved 1.5 cm incision, to expose the tentorial edge and third nerve. The tentorial edge three mm anterior to third nerve is retracted up and medially by a curved microspatula to reveal the internal carotid artery lateral to optic chiasm. The internal carotid artery is doubly clipped (Weck microhemoclips) or ligated (8-0 nylon) and divided one mm below its bifurcation, and the divided ends retract nicely. The 16 \times microscopic focus is then deepened and the optic chiasm and pituitary depressed gently with a small pledget. This permits exposure of the opposite internal carotid, which is similarly divided. One or two one cm gelfoam squares are placed at the operative site, and the dura is loosely approximated with several 8-0 nylon sutures. The wound is closed in two layers using 4-0 cotton interrupted sutures.

Six dogs underwent basilar ligation at a second stage, ranging from one week to four months. The basilar artery was exposed through a small four by eight mm oval, clival craniotomy using a high speed air drill. A five mm midline dual opening was used to expose the basilar artery just above the take-off of inferior cerebellar arteries, and about four mm above entrance of vertebrals (see Figure 1). The basilar artery was both clipped (Weck microclip) and ligated (6-0 silk) to insure its complete occlusion, but was not actually divided. The seventh dog underwent basilar occlusion acutely, one hour following division of both internal carotids.

All seven dogs survived. Four of the seven had a unilateral third nerve palsy, which cleared in all but one. Three of the seven revealed a transient hemiparesis, as manifested by circling towards the right side for the first several postoperative days. One dog developed a neurotropic corneal infection which caused severe scarring, but healed after a ten day course of topical antibiotics. The seven dogs otherwise appeared neurologically normal thereafter, and were observed for three weeks prior to sacrifice.

These seven dogs were sacrificed by exsanguination, using saline and 10 per cent formalin. The right common carotid artery was then hand injected with 40 cc. of micronized barium sulfate and an AP and lateral angiogram obtained. Then 50 cc. of latex compound was injected into the same common carotid, and the cranium removed and soaked in 10 per cent formalin for several days.

We were frankly surprised that these dogs survived complete occlusion of the three major intracranial vessels feeding the Circle of Willis, and sought to identify the remaining obviously effective intracranial anastomotic arteries. The angiograms were difficult to interpret due to the small size of these vessels, and careful microscopic dissection of the entire Circle of Willis proved to be a more accurate means of identifying these arteries. These proved to be of rather significant size (.2 mm) and constant location, comprised of an ophthalmic and ethmoidal artery on each side, both joining the proximal anterior cerebral. In addition to these four well developed intracranial collaterals, a few much smaller and variable dural to cerebral arterial anastomoses were found over each olfactory nerve, and around the pituitary gland. There is also normally a small (.05 mm) dural to basilar arterial twig, but in all our dogs this tiny artery had been taken down at the time of basilar ligation, and so was no longer present.

Contrary to the otherwise excellent descriptions of Netsky³ et al., we did not find any superior dural to pial anastomotic arterial connections, either over the cerebrum or cerebellum. This represents the first surgical exposure⁴ and isolation of the canine Circle of Willis in animals that survived in an intact neurologic state. It also demonstrates the effectiveness of the ethmoidal and ophthalmic intracranial anastomotic arteries, which enter the anterior half of the Circle of Willis, and in themselves are sufficient to supply cerebral perfusion requirements.

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Multiple Defects in the Colon

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DR. LEWIS GAYDEN: This is a case of a 74-year-old male with the chief complaint of right flank pain. Physical examination revealed a large mass in the right side of the abdomen. Proctoscopic examination was carried out and was of no diagnostic value. Dr. Patrick, would you comment on the barium enema examination?

Dr. Warren Patrick: The patient has a cecal deformity. Diverticula are scattered through the descending colon and sigmoid colon. There are multiple filling defects throughout the colon, the majority of these appear to represent fecal material. The most striking finding is the deformity in the cecal area. The appendix and terminal ileum are not identified. The possibilities to be considered are mucocele of the appendix, which could produce a defect in the cecal tip, mass formation with inflammatory lesion such as tuberculosis and granulomatous colitis and carcinoma of the cecum. The lesion has a sharp shelving margin distally but it does not have the usual nodular pattern of a fungating carcinoma.

Dr. J. L. Clements: Do you think that retrocecal appendicitis or granuloma secondary to retrocecal appendicitis could produce this appearance?

Dr. Patrick: This would be a possibility, but the most likely diagnosis to be considered is carcinoma of the cecum. Mucocele of the appendix can bulge into the cecal tip and produce a smooth, rounded defect; this defect is more irregular than I would expect to see with a mucocele.

Dr. Clements: Do you see anything else in the colon which may help you establish the etiology of the defect in the cecum?

Dr. Patrick: The patient has diverticulosis, possibly diverticulitis of the cecal area could produce this appearance; however, no diverticula are identified to be filled in the right colon. There is an irregular contour defect in the lateral aspect of the distal descending colon which has the appearance of carcinoma. In addition to that, there appears to be two



FIGURE 1

Portion of barium enema showing filling defects in the cecum as well as distal descending colon (large arrows) which proved to be multi-centric carcinomas. Smaller arrows point out polyps in sigmoid and transverse colon.

fixed filling defects, one in the transverse colon and one in the sigmoid colon compatible with polyps.

Dr. Gayden: If a patient has a malignant tumor in one segment of the colon, would it be more likely that a mass lesion in another segment of the colon is also a malignant tumor?

Dr. Patrick: I believe that this would be true. This patient could have multi-centric carcinomas, one arising in the cecum and the other in the distal descending colon associated with polyps in the transverse and sigmoid colon.

Dr. Gayden: The patient underwent surgery and a total colectomy was performed. Dr. Torres, will you discuss the pathological findings?

Dr. William Torres: The specimen consists of the entire colon, including a segment of the terminal

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

ileum. There is a large fungating carcinoma involving the cecum. The appendix is involved by the carcinoma, with obliteration of its lumen. A second primary carcinoma is demonstrated here in the descending colon. Histological examination of both of these lesions indicates adenocarcinoma. The two polyps present in the transverse and sigmoid colon represent adenomatous polyps with no evidence of malignancy. A third small polyp is found in the rectum.

Comment

This case demonstrates an entity which is well known but one which deserves periodic emphasis. The multi-centric nature of colon carcinoma has been noted for many years. This concept has steadily grown in acceptance over the past two decades. In 1956 a review of the literature revealed a total of 774 reported cases of multiple cancer of the colon.

In 1957, Moertel, et al. reviewed 6,012 cases of colonic carcinoma occurring over a 10 year period at Mayo Clinic. They found 261 or 4.3 per cent had multiple cancers. This study also showed once again the tendency to multiplicity in cancer of the colon associated with multiple polyps.

There was no doubt in their study concerning the marked tendency of simultaneous carcinomas to occur in the same region of the bowel. Twenty-eight per cent of the simultaneous lesions were confined to the same segment and 68 per cent to the same or adjacent segment.

As this case illustrates, unless attention is paid to the entire remaining colon, 32 per cent of simultaneous lesions could be missed.

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'THE KILLERS' FINDS A RECEPTIVE PUBLIC

An hour-and-a-half medical documentary on heart disease, first of a series of five programs titled "The Killers" presented over the 237 interconnected Public Broadcasting Service (PBS) stations around the country, was well received by Georgia viewers when it was shown November 19.

The series is designed to inform the public about methods of prevention, early detection and treatment of the five medical conditions that accounted for 75.7 per cent of all deaths, one and a half million, in the nation last year.

The remaining four subjects, and their air dates, are: inborn genetic defects, December 17; pulmonary disease, January 14; trauma, February 11; and cancer, March 11. Channels for watching the series via the Georgia Educational Television Network are available in the following cities: Savannah, Macon, Albany, Augusta, Waycross, Columbus, Chatsworth, Dawson and Atlanta.

A half hour follow-up panel discussion was held after the initial program on heart disease. Panel members included Bernard Bridges, M.D. of the Atlanta Medical Association, Inc., Nanette Wenger, M.D., chief of the heart clinic at Grady Memorial Hospital; and Jane Mc-

Combs, R.N., nurse-consultant for the Georgia Department of Human Resources. A toll-free, statewide telephone line allowed viewers to call in questions to the panel following the program. Barbara Piercecchi, program promotion director for Georgia ETV Network, said the phones rang without stop during the first 90 minutes of the heart disease program with questions from viewers.

A similar panel is planned for the December broadcast on inborn genetic defects and will include Dr. Arthur Falek with the Georgia Mental Health Institute; William Mason, M.D., of the Georgia Department of Human Resources; Lillian Warnick, M.D., chief of the Child Health Unit for the Georgia Department of Human Resources; Duane Blackstone, M.D., in private practice; and a representative from the National Foundation—March of Dimes.

In order to increase the effectiveness of the series, local PBS stations will utilize the shows as springboards for community action. Working with offices of 50 national health organizations, medical personnel and other interested citizens, many local television stations are planning programs tied into the series as well as community follow-up activities.

Governments and physicians must work together to minimize the effects of acute illnesses and accidents.

A Reasonable Emergency Health Services System: A Problem in Relationships

CARL JELENKO, III, M.D., *Augusta**

IN THE UNITED STATES more than 115,000 Americans were killed in accidents during 1972. More than 400,000 were permanently disabled and 10 million temporarily disabled during that year. Our economy lost 28 billions of dollars as a consequence of accidents—losses that could have been greatly reduced by upgrading our emergency medical services. It is more difficult to document deaths and disabilities due to accidents in Georgia—and to define those that occurred due to acute illness such as heart disease and stroke. It has been estimated, however, that approximately 2,000 Georgians will die on our highways *this* year; and that each death will represent approximately 18,000 dollars abstracted from our economy.

A System Defined

Furthermore, it has been amply demonstrated that a defined system of emergency medical services includes: thoughtful transportation and stabilization by trained personnel; properly equipped ambulances; competent hospitals and physicians; and a realization that certain disease entities are beyond the capability of a particular institution, requiring that the patient be transferred immediately to one able to care for him.

Over the last three years, Georgia has made progress which outstrips most other states in developing an administrative network that is ripe for the establishment of a model state-wide system of emergency health care. These advances have included the enactment of enabling legislation to provide for physi-

cians assistants; trained ambulance personnel; reasonably equipped emergency departments; safe, well-equipped ambulances; and complimentary safety-oriented acts. It is clear, however, that we, as a state, can go no further until we are willing to do it in such a manner that the entire governmental structure becomes committed and involved.

It is clear that from a humanitarian standpoint all of us desire the same goals: to eliminate—or at least minimize—deaths and disabilities from acute accidents and illnesses. However, it is clear that a very practical set of problems confronts us which makes it difficult to reach our humanitarian goal.

Too Much, Too Few

In the first place, Georgia is an enormous state in terms of land mass, but contains a disproportionately small population. In our 159 counties, only 4.5 million people live—most of them in a few large cities. Our system of roads is not favorable for rapid transportation of patients in the most rural areas to medical centers capable of caring for them. Among our 156 general hospitals, only 35 have the capability in terms of personnel, beds, and equipment to care for major accidents and illness. Furthermore, only seven of these hospitals are sufficiently well-equipped (according to the categorization criteria of the American Medical Association and American College of Surgeons) to handle virtually *any* medical situation. By far, the bulk of our hospitals are staffed by too few physicians, or by too few nursing personnel, or have too few beds or emergency rooms that are too underdeveloped to serve as more than places where patients can be stabilized prior to evacuation to more appropriate facilities. Ambulance services are often overburdened by the need to serve a population group and/or area mass too great for their capabilities. Communications networks are either

* Dr. Jelenko is professor of surgery at the Medical College of Georgia. He serves as chairman of the MAG Emergency Medical Services Committee; chairman of the Georgia State Committee on Trauma of the American College of Surgeons; vice-chairman of the Advisory Council on Emergency Health Services to the Board of Human Resources; and councilor to the University Association of Emergency Medical Services.

This article appeared in the August issue of the Georgia County Government Magazine and is reprinted with permission of the publisher.

overburdened, inadequate or non-existent.

And most important as an impediment in establishing an adequate emergency health services system, insufficient federal and/or state funds have been identified to support a system. Additionally, the county and municipal governments have not yet indicated clearly to the state and its legislators their desire for this important service for their citizens.

It has been argued by some that medical care—and particularly emergency care—is not a privilege, but rather a right. But thus far a considerable problem has existed amongst our various counties in identifying their need for—and desire for—establishment of capability to deliver this right to their people. It has been manifestly clear that one of the major problems is a fiscal, tax-based difficulty. County A is unwilling—and rightfully so—to force its citizens to pay the price in money, goods, and services to care for county B's indigent population. For this reason, it has been difficult to establish area-wide systems that identify a central locus to which emergency patients can be brought and at which care can be delivered. Disaster planning suffers from the same impediment. And clearly, the only rational way to deliver this type of health care on a reasonable service/cost basis is by developing a series of interlocked regional sub-systems.

Again, the problem is money. How can we—the governmental bodies and medical/paramedical providers identify a reasonable way to cost-out care, *prorate the costs appropriately*, and indicate in a viable manner to the legislature that an identifiable amount of dollar support is needed?

In short, the question is: How do we work *together* to establish a reasonable system of emergency health service in Georgia?

It seems to me that we could begin a dialogue with each other to determine what the governmental bodies can do; what they are willing to do; and where and how funding should arise. The providers can give valuable expert assistance in indicating what they can and will do to furnish services, identify services, and work alongside the various governmental bodies to assure that funding be attained.

The Emergency Medical Services Committee of the Medical Association of Georgia; the Georgia Hospital Association; the Georgia Association of Funeral Directors; the Trauma Committee for Georgia of the American College of Surgeons; and other similar bodies have many times expressed—and recently re-affirmed—their willingness and desire to work with government to attain the goal of establishing an optimal emergency health care system in Georgia at a reasonable cost which does not unduly burden any of our citizens.

The purpose of the foregoing is simple: to indicate to the members of the Association County Commissioners of Georgia the willingness of the medical/paramedical community to work with you to establish a dialogue aimed at solving our common problem. Further, it is our purpose to tell you clearly that we need your help and, simultaneously, to solicit that aid.

N. B. In the August '73 issue of *Georgia County Government Magazine* (page 26) a similar article was published by the author. To date (12/73) no response has been forthcoming. It is hoped that MAG members with contacts among Chairmen or County Commissioners will help these individuals understand the problem and need for cooperative effort.

Medical College of Georgia 30902

'SESAME STREET' CREATORS ANNOUNCE PRIME TIME HEALTH SERIES

A major new prime time television series on health, designed for an adult audience, is being developed by the Children's Television Workshop, creators of "Sesame Street," and will premiere on the nation's 240 public broadcasting stations beginning in the fall of 1974.

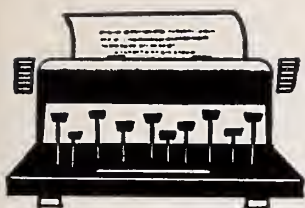
Some 26 original, hour-long programs will be created for the series' first experimental season, providing practical health information in an entertaining and instructional form, utilizing a variety of proven techniques ranging from music and dance to drama and documentary. Research, development and production phases of the first season are budgeted at \$7 million.

A primary target audience of the program will be the young parents who play major roles in the general health and nutritional well-being of their immediate

families. The needs and problems of the poverty family will be of particular concern.

The objective of the series will be to get people to improve the level of their own health and that of their family, explore means of gaining access to the nation's health delivery system and examine some of the new aspects of that system.

Supplementing the weekly video message will be follow-up projects conducted in conjunction with local public television outlets and enlisting the aid of local health agencies and neighborhood groups. Promotional materials, including printed program guides for mass distribution, a series of instructional posters and other special publications are planned to help reinforce the health messages contained in the series.



Saving Absurdity

*"How could the Eternal do a temporal act,
The Infinite become a finite fact?
Nothing can save us that is possible:
We who must die demand a miracle."*¹

DISGUISE IT AS WE WILL, this is the question that confronts a sophisticated and initiated age. While deep emotional sentiment binds us to the reported events of those days, we feel intellectually liberated from the hocus pocus about angels and visions, star gazers and strange prophecies. Indeed we have quite transcended immediate limitations. What with the computer, the unleashed power of the atom, the infinitely accurate eyes of the electronic telescope and the probing finger of the laser beam, we feel few restraints. Let's face it, we don't live in a Bethlehem sort of world. Claims made long ago by peasant folk in that little town are frankly just a bit embarrassing to a people who have completed round-trip journeys to the moon. So with Auden's chorus there is a persistent note of cynicism in our question, "How could the Eternal do a temporal act, The Infinite become a finite fact?"

Yearnings of the Spirit

But in spite of effervescent confidence and claim to seemingly unlimited resources in technique power and knowledge, there is a nagging uneasiness. All of this just does not quite pull it off. Credit the whole experience to nostalgia and sentiment, there is nevertheless something of the human spirit that yearns for the peasant-like simplicity of the shepherds' story.

In one of those stories inextricably tangled with myth, out of Israel's past, Jacob wrestles with a strange and darkened figure. Whatever else the story portrays in its anthropomorphic style, it finds man and God wrestling, struggling and calling for each other's name. So it is that the psalmist speaks concerning God, "He who planted the ear, does he not hear? He who formed the eye, does he not see?" The prophets carry on their dialogue with God as man to man. We smile at such crudity but we also yearn. When Matthew records that "the birth of Jesus took place in this way," what follows is a sordid account at best, as far as the proprieties of society are concerned. God disclosed as a Babe in a poor and inconspicuous home, one who had a manger for his first cradle, with all kinds of strange people crowding in between camels and donkeys to look at him . . . the name "Jesus" as common as our names "John" and "William." The name is human. The footsteps of his common humanity are dogged by the unbelief of those who insist on some spectacular visage. "Is not this simply Joseph's son . . . you know, the carpenter from the town of Nazareth?" Jesus of Nazareth, no abstract principle, no angelic visitation, no mathematical theory but a man like you and me, a man surrounded and boxed-in by the presence of a Caesar, of a governor, of citizens and officials; a man lo-

cated by a place, one who went from place to place. And it all ends as an insignificant footnote so far as the Roman Empire is concerned.

God Is Like Me

How embarrassingly absurd that we, with our penchant for worshipping heroes and success, with all our know-how and debonair inclinations, should be caught referring to this peasant as Lord! So Advent in our time means many things, but one thing certainly, is the saving absurdity that God is like me, that He redeems my humanity. Advent is looking into the mirror and knowing the reflection is God-like. Advent is looking deeply into the faces about you and knowing that there is God in all of his absurd fullness. Advent is looking into the faces of joyful children or even hungry and embittered children and daring to say there also is God. And so, Tillich's thought that "The completely concrete being, the individual person, is the object of the most radical concern—the concern of love. . . ."² Here then, is the deeply human cry of Advent that we may experience our true humanity . . . not a percentile on some sliding statistical scale . . . not a faceless digit on a demographic chart . . . but a human face, one that walks with us and wrestles with us in the throes of existence; one who in the very absurd image of our likeness, saves us.

"Therefore, see without looking, hear without listening, breathe without asking;

The Inevitable is what will seem to happen to you purely by chance;

The Real is what will strike you as really absurd;

Unless you are certain you are dreaming, it is certainly a dream of our own;

Unless you exclaim—"There must be some mistake"—you must be mistaken."³

*The Rev. Allison Williams
Trinity Presbyterian Church
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Atlanta, Georgia 30327*

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3. Auden, W. H.: *op. cit.*, p. 412.

Medical Legislation Outlook for 1974

TOMORROW IS TOO LATE. The Georgia General Assembly is interested TODAY in knowing what you as physicians of Georgia, and as tax-paying citizens of Georgia, feel about specific pieces of legislation that affect you. Your representatives and senators realize that you are the experts in this field and not themselves.

During the 1973 Georgia General Assembly, the Medical Association of Georgia took an active part in passing, defeating, or changing some 60 different bills. Out of these, much good legislation has now become law, much bad legislation was turned down, and numerous bills await further investigation and study. The time and effort many of you put forth last year in contacting your representatives and senators on numerous bills paid off when a vote was called. Additional association and communication with your legislators is needed whether it be on the golf course, at a Christmas party, church, or elsewhere. This type of relationship is extremely valuable to the medical profession when advice is sought by our lawmakers.

Your legislative representative, Rusty Kidd, can be reached at 938 Peachtree Street, N.E., Atlanta, Georgia 30309. His phone number is 876-7535 in the Atlan-

ta area, or outside this area dial the toll-free WATS line 1-800-282-0224. Mr. Kidd personally knows all of our representatives and senators and will be able to give additional information concerning each one if this is needed.

Bills of interest to MAG which will be coming up in 1974 session include:

CERTIFICATE OF NEED: House Bill 504 was introduced in 1973, passed the House of Representatives, and is presently pending in the Senate Health and Welfare Committee. This Bill states that any hospital or related institution could not be constructed or expanded unless a Certificate of Need is issued by an appointed committee of the Governor. This type of bill can be expanded to include a Certificate of Need for professionals and their respective fields. Viewed as a detriment to the free enterprise system and individual rights to choose the geographic area in which to practice, MAG opposes this type legislation.

CHIROPRACTORS AND MEDICAID: MAG opposes the inclusion of chiropractic services in Medicaid as an injudicious use of tax funds and a backward step in efforts to maintain high quality health care for all Georgians. House Bill 858 was introduced in 1973 and is still pending in the House Human Relations Committee. The U.S. Department of Health, Education and Welfare, the AFL-CIO and the National Council for Senior Citizens are among the many groups which have opposed the inclusion of chiropractic services in government health programs.

CHIROPRACTIC INSURANCE COVERAGE: House Bill 147 was defeated in the House Insurance Committee last year. However, this bill remains live and a similar bill is proposed for introduction in the Senate next year. The chiropractic profession was extremely upset by this defeat last year and now with the inclusion of chiropractic services under Medicare, they hope to enact similar legislation of House Bill 147 during the 1974 General Assembly.

The Legislative Committee of MAG feels that it is imperative for all members and their associates to assume an aggressive stance in defeating chiropractic legislation.

The Medical Association of Georgia has two tentative bills to be introduced in 1974 limiting chiropractic in Georgia. The *Journal* and regular Legislative Bulletins will keep you informed as to the number of these bills, their status and the best possible way you as a MAG member can assist in the passage of this legislation.

HYPNOSIS: House Bill 370 passed the House of Representatives last year and is presently pending in the Senate Institution and Mental Health Committee. Our efforts are trying to convince the chairman of this committee to act on this bill so as to limit the use of hypnosis to licensed physicians and dentists in Georgia.

HEALTH MAINTENANCE ORGANIZATIONS: House Bill 998 introduced in 1973 is still pending the House Health and Ecology Committee. The Medical Association of Georgia is opposed to the development of contract practice HMO's in Georgia. As an alternative to such organizations, MAG supports the development of Foundation Medical Care Plans.

MAG's Committee on Legislation has certain principles which it feels organized medicine should support in any enabling legislation for prepaid comprehensive care organizations.

ACUPUNCTURE: It is the feeling of many legislators around Georgia that some type of legislation should be enacted next year limiting the use of acupuncture to physicians or to be in the direct control of a physician in a proper medical atmosphere. These legislators think the law should be strong enough so that anyone using acupuncture illegally would be fined \$1,000 or more for the first offense. Your Legislative Committee will keep abreast of this action and will have input in any type of bill concerning acupuncture.

ABORTION: The Abortion Bill which passed the Georgia Legislature last year had MAG's support. This bill simply followed the guidelines mandated by the U.S. Supreme Court. We are told that the Right for Life Group will sponsor its abortion

legislation again next year. It is our hope and intent to defeat that bill, thus, keeping the abortion law as is today.

NEWBORN INSURANCE COVERAGE: Undoubtedly some form of legislation will pass the 1974 Georgia General Assembly concerning insurance coverage for the newborn. MAG, the Georgia Chapter of the American Academy of Pediatrics, the insurance industry and others are trying to reach a suitable solution to this problem.

1974 IS A CAMPAIGN YEAR. Physicians need to become active with their politicians. During this year, we can evaluate the ability of our legislators to represent not only physicians but Georgia as a whole. It is during this time we can decide whether or not to support the incumbent or possibly find a suitable replacement. *Become aware, become informed to the political scene in Georgia.* These are trying times for the medical community. It is time for physicians to band together for the betterment of all Georgians.

HIGHLIGHTS EXECUTIVE COMMITTEE OF COUNCIL

October 21, 1973

Insurance Coverage for Psychologists: Referred to the Legislative Committee report from Georgia Psychological Association favoring compulsory inclusion of psychologists' services under insurance program cover in mental health care.

Medical Profile Systems: Received report on "Life-Sign" card containing microfilm health data to be offered as a service in Georgia and referred to Committee on Private Practice Membership and Interspecialty Council.

Newborn Insurance: Reaffirmed support of mandatory coverage for newborn from birth if dependent coverage is in a policy with consideration and final action to be taken by Council in January.

State Medical Program: Referred consideration of Governor's New Health Legislation package to MAG committees as well as specialty societies deemed appropriate by Committee on Private Practice.

Medical Disciplinary Board: Adopted position of seeking Composite Board agreement on any MAG proposals to change Medical Practice Act with reciprocity expected from the Board.

Restriction of Drug Sample Distribution: Request-

ed report from Pharmaceutical Manufacturing Association after receiving recommendation from Georgia Pharmaceutical Association to restrict drug sample distribution.

Acupuncture: For reimbursement purposes recommended third parties treat acupuncture when performed by a licensed physician as they would any other new procedure.

Proposed Medicare Regulations: Received report from Atlanta Blue Cross on implementation on new controls of Medicare patients' hospitalizations and recommended development of informational campaign for physicians and Medicare beneficiaries to explain possible deleterious effects of these regulations.

AMA Delegation: Designated Alternate J. Dan Bateman, M.D., Albany to fill the seat of the late J. Frank Walker, M.D. at AMA Clinical Session in Anaheim.

Protocol of Joint Medical Care—M.D. and R.N.: Approved protocol as recommended by Joint Practice Committee and referred it back for reconsideration based on new circumstances and personnel changes at Southside Health Center.



MECHANISM FOR MEDICAL DISCIPLINE

MEDICAL DISCIPLINE MEANS DIFFERENT things to different people. To a patient it could mean someone should intercede and adjust a fee that the patient feels is exorbitant or chastise a physician who has been rude or negligent.

To members of the medical profession, medical discipline has many facets and many extremes. There are those who would deprive a fellow physician of his license without due process of law because the quality of care he delivers is, in their opinion, not of the quality that the consumer or patient should receive. At the other end of the spectrum are those who adopt the position that any and all physicians should practice as they see fit and woe be it unto the patient or consumer.

Enforcing the Medical Practice Act

Happily most physicians' concepts of medical discipline lie between these two extremes, and the majority of these physicians are aware of the many varied problems that our Composite State Board of Medical Examiners encounters in its conscientious effort to enforce the Medical Practice Act. This board and this board only has the authority to grant, suspend or revoke your medical license under the authority of the Medical Practice Act. The board is made up of 10 MD's and two DO's, all currently appointed by the Governor. It is a legislative body and hence is granted investigative authority and enjoys the legal protection of the Office of the Attorney General of Georgia.

Many contend that the Composite State Board has been derelict in its duties for not undertaking investigation and subsequent disciplinary action on occasions that perhaps warranted such actions. The Composite State Board must use unskilled, non-medical police officer type personnel from the Attorney General's office for investigative purposes. The Legislature does not provide the Board with funds for hiring skilled professional investigative personnel. The Board is made up of physicians who all are actively practicing medicine. They do not individually have the time to investigate all complaints that come to them.

Investigative Committee

The Medical Association of Georgia and members of the Composite State Board are aware of these problems. MAG has asked the Composite State Board for its assistance and guidance in an attempt to formulate jointly a medical investigative

disciplinary committee made up of physicians who would, under the authority of the Composite State Board, attempt the initial investigation of complaints. Hence, doing away with the police officer approach.

All agree that physicians can best scrutinize other physicians. The attorney general negated our plans. There is no provision in the Medical Practice Act for such actions by the State Board.

We will not give up. We need this investigative disciplinary board in order to provide peer investigation of complaints against physicians. The Medical Practice Act has the necessary provisions for discipline. However, I contend that should we get an investigative disciplinary board, and if this board functions properly, the idea of peer investigation will, in many instances, cause a wayward physician to straighten up and fly right.

Our friends on the Composite State Board will have the Attorney General's office present legislation that will enable us to set up such a board.

MAG is enjoying excellent rapport with and the full cooperation of the Composite State Board of Medical Examiners and we feel we will accomplish our goal in 1974 to establish a satisfactory mechanism for medical discipline in our state.

Beginning in 1975, MAG will submit to the Governor the names of three physicians from each congressional district. Each time a vacancy occurs on the Composite State Board, the Governor may select one of the three for the position. There is a possibility that this would be unconstitutional should a physician who is not a member of MAG come to trial before a board made up entirely of MAG members. I feel this possibility should be explored thoroughly by our legal staff and the Attorney General before we find ourselves in an embarrassing position.

Merry Christmas and a Happy New Year from Billie and me.



Charles Emory Bohler, M.D.
President, Medical Association of Georgia

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

November 4, 1973

Medical Examiners System: Received study proposal to examine other state systems of medical examiners. Referred to Georgia Association of Pathologists.

Certificate of Need: Received report from the office of Comprehensive Health Planning on low occupancy rate in many Georgia hospitals. Referred to Private Practice Committee for study and report to House of Delegates.

Reorganization of MAG: Heard report on first committee meeting with initial priorities set as (1) definition of executive director's authority, and (2) organization and composition of Council.

EMCRO: Heard report on cost of EMCRO hospital abstract systems tentatively estimated to be 75 cents per hospital discharge abstract.

Appointments: To the Physician-Lawyer Liaison Committee chairmanship, T. A. Sappington, M.D., Thomaston; JMAG Contributing Editors, Donald J. McKenzie, M.D., Thomasville; Committee on Reorganization and Structure, R. Beauvais Randall, Jr., M.D., Decatur; Ad Hoc Committee on OTC State Medicaid Drug Vendor Program, Stanley P. Aldridge, M.D., Decatur, as chairman, W. Dan Jordan, M.D., Atlanta and Judson L. Hawk, M.D., Atlanta; Regional Advisory Group chairman, Mr. Gary S. Cutini; MAG (Benevolent) Foundation, Earnest C. Atkins, M.D., Decatur.

MAGNET: Commended Robert Wight, M.D., of Tifton, chairman of the Communications Committee, for excellence of the MAGNET program.



THE SECOND HEART SOUND— POTENTIAL PITFALLS IN ITS CLINICAL INTERPRETATION

THOMAS L. CREWS, M.D., *Covington**

PROPER AUSCULTATION OF THE HEART demands that the examiner accurately identify the respiratory variation and relative intensities of the aortic (A_2) and pulmonic (P_2) components of the second heart sound (S_2), as well as the relation of other sounds and murmurs to these components. This phase of auscultation is performed with the stethoscope diaphragm at or near the pulmonary area with the patient reclining at 30° - 40° . Normally, A_2 is louder and occurs earlier than P_2 during inspiration with the two sounds fusing, or nearly so, with expiration. The major contribution to inspiratory splitting of S_2 is made by a delay in P_2 , that reflects an increase in right ventricular stroke volume coincident with the augmented venous return to the right heart during inspiration. Abnormalities of inspiratory splitting and expiratory fusion of S_2 can provide the physician with important clinical information, but diagnostic pitfalls must be avoided.

Causes and Locations

Fixed splitting of the second sound is usually due to inability of the right ventricle to vary its stroke volume. Fixed splitting is frequently present with right ventricular failure and with atrial septal defect. A more common abnormality in adult patients is persistent audible expiratory splitting of S_2 that results from a delay in P_2 , and early A_2 , or a combination of both. Persistent expiratory splitting may occur in the presence of right bundle branch block, pulmonic stenosis, pulmonary hypertension, mitral stenosis, and ventricular septal defect. Persistent expiratory splitting can easily be misinterpreted as fixed splitting and both conditions can be erroneously diagnosed in the following situations: when the respiratory rate is so rapid that normal splitting cannot be appreciated (common in very young infants); when a late systolic click occurs prior to A_2 and a soft P_2 is missed; or finally when an opening snap or a third heart sound follows A_2 , and P_2 is missed.

Reversed splitting of the second heart sound occurs when left ventricular activation is delayed or left ventricular systole is prolonged to such extent that A_2 occurs after P_2 . Hence, with inspiratory delay of P_2 , the second sound becomes single with inspiration and widens in expiration. Frequent causes of this phenomenon are left bundle branch block, an artificial pacemaker with the electrode in the right ventricle, systemic hypertension, aortic stenosis, and ischemia of the left ventricle. Misdiagnosis of reversed splitting is made most commonly when pulmonary hyperinflation is present and the inspiratory increase in insulation between stethoscope and heart causes a soft P_2 to become inaudible. On rare occasions, when mitral regurgitation with pulmonary hypertension is present, A_2 may be lost in the apical pansystolic murmur or dwarfed by the loud P_2 thus permitting a loud ventricular filling sound (S_3) to be erroneously labeled P_2 creating the mis-

* Prepared at the request of the Committee on Professional Education of The Georgia Heart Association.

taken impression of reversed splitting. This misdiagnosis would be made only when attempting to evaluate S_2 at the mitral area, and would be corrected when auscultation near the base of the heart revealed A_2 in its proper relationship.

A single second heart sound persisting throughout the respiratory cycle may be present when the two ventricles are functioning as one against identical pulmonary and systemic pressures; when pulmonary flow is diminished to the point that P_2 becomes inaudible; when left ventricular ejection is disproportionately prolonged in old age; or when the aortic valve leaflets become calcified and movement is so restricted that A_2 is inaudible. A single S_2 may occur with large ventricular septal defects and Eisenmenger physiology; Fallot's Tetralogy; Pulmonary Atresia; Severe Calcific Aortic Stenosis; and Corrected Transposition of the Great Vessels. Severe pulmonic stenosis and noncalcific aortic stenosis are conditions which may give the mistaken impression of a single S_2 since the long ejection murmur may engulf A_2 or P_2 . A careful search, however, will usually reveal the missing component.

4114 Mill Street, N.E. 30209

TOP EXECUTIVES WIN THE BATTLE OF SURVIVAL OF THE FITTEST

Is the top executive, beset with pressures, working himself to death? Definitely not, according to a Metropolitan Life investigation which shows that being an executive is not an occupational health hazard. In fact, as a group, top executives enjoy better health and longer life than their subordinates in the uncarpeted offices down the hall.

Mortality rates were studied among thousands of employees of several of the nation's largest corporations and executives were found to have by far the best health record in the industrial population. A Metropolitan Life investigation of 6,000 men listed in *Who's Who in America* in 1950-51 over a 12-year period shows that while they do not experience as favorable longevity as doctors, lawyers and scientists, prominent businessmen, as a group, had a death rate only 70 per cent that of white males in the general U.S. population—three per cent lower than expected.

The conclusion was that this favorable mortality reflects the physical and emotional fitness of prominent men for positions of responsibility. They can take the pressures, thrive on work and show the survival of the fittest in more ways than one.

For those who are prone to tension, the advice is given that such executives have periodic emotional checkups, take time to evaluate their goals, particularly those concerning family relationships, schedule time for vacations and hobbies. They were reminded by Metro-

politan to gear their lifestyles in the interest of good health and prolonged life, avoiding bad habits that promote high blood pressure and heart disease.

VA HOSPITALS PLAY A MAJOR ROLE IN MEDICAL EDUCATION

Figures released by the Veterans Administration show that about half of the physicians being produced in the United States receive some of their training in a VA hospital.

In fiscal 1973, the VA hospitals assisted in the training of 28 per cent of the nation's medical students, 25 per cent of its new medical specialists, and 21 per cent of its interns. More than 65,000 physicians, nurses and other health workers received clinical training in the agency's hospitals during fiscal 1973, an increase of 9,000 over the previous year. This 1973 total includes 13,583 residents and interns who received all or part of their postgraduate medical education in VA hospitals.

The administration says it now has close working affiliations with 89 medical schools, 57 dental schools, 314 schools of nursing and 45 schools of pharmacy, plus affiliating programs in graduate psychology, social work and other allied health professions and occupations in more than 800 schools.



MEDICAL STAFF BYLAWS

JAMES H. KEATEN *and* DAVID M. RAPP, *Atlanta**

A NUMBER OF RECENT INQUIRIES to MAG would indicate a great deal of interest among physicians in the legal aspects of medical staff bylaws. We therefore thought that this article might be timely.

The bylaws of a hospital medical staff serve as the basic grant of authority to the medical staff—a sort of constitution. The bylaws organize the medical staff, describe its functions, and prescribe the standard of conduct and duties of its members. They do not, and should not, attempt to provide for the day to day operation of the staff in detail. Rather, they establish the framework within which the staff and its various committees may work out those details. Each physician on the staff should be familiar with the bylaws since staff members are typically required to agree to abide by the provisions, including such things as rules and regulations and committee assignments.

Guidelines Available

The Joint Commission on Accreditation of Hospitals has published guidelines for the formulation of medical staff bylaws for both departmentalized and non-departmentalized hospitals. These guidelines should be treated as such—they do not pretend to be a set of model bylaws which should be adopted verbatim. Each staff must govern itself in conjunction with its own governing authority, the laws of the state and the rules and regulations of the Department of Health. Rather than recite the suggestions of the Joint Commission, this brief article will attempt only to highlight some areas of the guidelines and point out where problems have arisen in the past.

Where there are sufficient practitioners on the staff to warrant a system of government within each specialty, the staff may be divided into clinical departments. The executive committee of the medical staff should probably recommend initial departmental assignments for medical staff members. Each department should be headed by a chairman whose qualifications and functions are set forth in the bylaws. The department chairman should be responsible for the professional and administrative activities in his department.

The Joint Commission Guidelines envision that each department will establish its own criteria for the granting of clinical privileges. Provision should be made for general practitioners to have clinical privileges in one or more departments consistent with their education, training, experience and demonstrated competence.

Establishment of Committees

The bylaws should establish medical staff committees for various purposes. The Joint Commission Guidelines suggest the following committees: executive commit-

* Prepared at the request of The Medical Association of Georgia. Mr. Keaten is a partner and Mr. Rapp is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

tee; credentials committee; joint conference committee; medical records committee; utilization review committee; pharmacy and therapeutics committee; infection control committee; and committees for special services and/or functions.

The staff may consider establishing committees to deal with such further matters as: accreditation; cancer; the constitution and bylaws; disasters; the emergency clinic; intensive care; continuing medical education; the library; nursing; transfusions; grievances; and the like. The bylaws may also establish committees with responsibility for specialized areas and ad hoc committees as the need may arise. Special attention should be given to the establishment of committees to make those recommendations which may be required by law, such as a committee for the review of proposed sterilization procedures, as contemplated by Section 84-933 of the Code of Georgia.

Appointments to the Medical Staff

The Joint Commission Guidelines suggest that all initial appointments to any category of the medical staff should be provisional until the end of the medical staff year. During the period of provisional appointment, the performance of the provisional staff member should be reviewed by the members of his department; he is then either advanced to regular staff membership or terminated.

From the standpoint of litigation, clearly the most controversial areas of the medical staff bylaws are the provisions for admission to and exclusion from staff privileges. The physician who is refused appointment to staff membership or whose membership is terminated has certain rights which must be observed.

The courts have frequently held that where the bylaws deal with both the substantive question of an applicant's qualifications and procedural questions concerning the mechanics of the appointment or removal process, the bylaws must be followed in all cases. This raises the tactical question of how specifically the bylaws should prescribe the appointment and removal procedures.

Great specificity could conceivably cause a severe strain on the process. For instance, if the Credentials Committee or some other body is tied to a strict timetable in evaluating the professional competency of an applicant, the committee may be unduly restricted in properly performing its duty.

Such an incomplete evaluation of an applicant could have very significant consequences. The Supreme Court of Georgia has held that a hospital could be liable for damages to a patient if the hospital negligently permitted an incompetent or unqualified practitioner to use the hospital's facilities in treating a patient, and as a result the patient was injured. Thus, this exposure to liability on the part of the hospital, as well as the attending physician, places an affirmative duty on the hospital to evaluate thoroughly the credentials of each applicant.

The objectives of the appointment and removal procedures are essentially two-fold: to insure the quality and competency of the staff members and to provide fairness to the physicians involved. More specifically, with regard to the latter objective, the physician is entitled to receive due process and equal protection of the law in the procedure.

The qualifications for staff membership set forth in the bylaws of a public hospital must be reasonably related to the efficient and orderly operation of the hospital; the standards must not be arbitrary, capricious or unreasonable. On the other hand, it has long been recognized that a physician has no constitutional right to membership on the staff of a public hospital merely because he is licensed by the state to practice medicine.

Wide Discretion

Several courts have recognized that staff selection involves subjective factors which would be difficult, if not impossible, to codify in the bylaws of the medical

staff. Therefore, the governing body of a hospital must be given wide discretion in prescribing the necessary qualifications for staff membership. The determination of a physician's competency for staff privileges need not depend solely on objective factors such as education and training. Numerous cases have upheld the suspension or dismissal of physicians because of their demonstrated professional incompetence or bizarre working habits which made it difficult for the other staff members properly to function.

There are only a few Georgia cases on this subject. However, a review of some of the cases from other states should be informative. The U.S. Fifth Circuit Court of Appeals has held that staff bylaws which required applicants for admission to the staff to be members of the local county medical society violated the equal protection clause of the Fourteenth Amendment. The court found that membership in the county medical society was not reasonably related to the express purposes for which the medical staff was formed. Similarly, an Arkansas court struck down, as unreasonable and discriminatory, a bylaw which made approval and recommendation by the county medical society a prerequisite to use of the hospital's facilities.

In some jurisdictions in this country bylaws have been upheld which required applicants to be graduates of medical schools approved by the American Medical Association, thus excluding, for example, osteopaths because of their school of treatment. However, the clear trend in the law is toward granting privileges to all qualified and competent physicians, including osteopaths, who are licensed by a single Composite Board of Medical Examiners, as in Georgia. On the other hand, a recent federal decision arising out of Georgia has upheld the blanket exclusion of podiatrists from staff privileges.

Even where the requirements for staff membership have a reasonable relationship with the welfare of the hospital, the requirement may be invalid if it is likely to be discriminatorily applied. The U.S. Fifth Circuit has struck down a bylaw that required applicants for hospital staff membership to submit an application signed by at least two members of the active medical staff who vouched for the applicant's character and general fitness. The court found that the necessary recommendations *could* be arbitrarily and discriminatorily withheld.

The standards for staff membership must also be implemented in compliance with procedural due process, and virtually every court which has had occasion to decide the question has so held. As a general rule, the requirements of procedural due process include permitting the physician to appear and be heard before the committees or other bodies considering his case and permitting him to be represented by counsel.

Private Facilities

The bylaws of the medical staff of a private hospital should not differ significantly from those of a public hospital. In theory, the due process requirements for appointment to or removal from staff privileges in a private hospital may not be as stringent as those for a public hospital, but this is not a cut and dried issue. The Supreme Court of Georgia has stated that a distinction can be drawn between public and private hospitals in this respect, but the Court has not elaborated on the nature or extent of that distinction. It is doubtful that a private hospital may, in its absolute discretion, prescribe arbitrary, capricious or discriminatory rules and regulations or requirements for staff membership.

Some cases have held that a private hospital is so closely linked with the public interest that it cannot be totally free from judicial control. A New Jersey case following this approach struck down the bylaw of a private hospital that required medical staff members to be graduates of medical schools approved by the American Medical Association on the ground that a blanket exclusion of osteopaths was unsound and not in furtherance of the public good.

A number of cases have held that where an otherwise private hospital has received federal or state funds so as to become an instrumentality of the government,

then the acts of the hospital will be held subject to the Fifth and Fourteenth Amendment requirements of due process and equal protection, under the theory that the acts of the hospital have become "state action." For example, where two private hospitals received substantial Hill-Burton funds, the Fourth Circuit Court of Appeals struck down a regulation denying staff privileges to those physicians whose practices and offices were outside the county in which the hospital was located. This was held to be unreasonable and a denial of equal protection.

Recent developments indicate that the Civil Rights Act of 1866 (enacted during Reconstruction) *may* apply to persons denied staff membership in a private hospital because of their race, creed or color. The Act no longer is interpreted as requiring state action to trigger its protection. Thus, even a private hospital may in some cases be guilty of denying an individual's civil rights by excluding him from staff membership.

Conclusion

As a final matter of some importance, the medical staff bylaws should enable the staff to adopt such rules and regulations as may be necessary to implement more specifically the general principles established by the bylaws. The courts of Georgia have consistently held that the practice of medicine may be regulated where the public welfare demands. The bylaws, rules and regulations of a hospital may restrict a physician's right to practice according to his own unfettered judgment.

In summary, the bylaws of the medical staff constitute the internal body of law which controls the functioning of the staff, subject to limitations imposed by constitutional and statutory provisions and the governing authority. The bylaws accordingly deserve careful consideration both in their drafting and in their observance.

It should be reiterated that the purpose of this article has only been to highlight briefly a few items of interest in the area. The subject is too large to cover all of its aspects here, and we suggest that any review of the medical staff bylaws include the assistance of an attorney.

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C&S National Bank Building 30303*

STANDARDS FOR SURGEON'S ASSISTANTS ADOPTED BY AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons has adopted standards designed to promote high-quality training of surgeon's assistants, one of several new categories of health workers developed in the past few years. These standards, published in a recent edition of the College's *Bulletin*, set forth requirements for the training institutions and their facilities and faculties, prerequisites for admission to an assistants' program and the basic curriculum.

The standards were developed following the conducting of a survey to which more than 8,000 of the College's 15,500 Fellows responded. The physicians indicated that they would utilize trained, competent assistants. Dr. C. Rollin Hanlon, director of the College, says, "It is an undeniable fact that surgeon's assistants are being produced, that programs for their education do exist, and that there has been heavy pressure on the College to set standards for these educational programs."

He noted that the standards were "not designed to stimulate production" of these assistants, but to set high standards for them.

Among other things, the standards call for completion of two years of college or the equivalent prior to admission to a surgeon's assistant training program, and a suggested program for the curriculum calls for one academic year of pre-clinical training and one of clinical training. Courses suggested include gross anatomy, medical terminology, medical physiology, introduction to medicine, medical history and physical examination, sterile technique and introduction to the operating room, principles of surgical patient care, surgical care techniques, introduction to x-ray interpretation, electrocardiogram recording technique and interpretation of cardiac problems, pulmonary function tests and inhalation therapy.

I've told this before

(Ed. note: Our series of human interest stories by physicians and their families continues with a special Christmas story which emphasizes the merry mood of the season shared by people of different nationalities. Atlanta's J. G. McDaniel, M.D. writes of his son's enjoyment of "Christmas Dinner at the Hofbrau haus." Others wishing to contribute should send their stories to the Journal of the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.)

Christmas Dinner at the Hofbrau haus

MY YOUNGEST SON GEORGE tells of a joyful Christmas that he and some friends had in Bavaria in 1964.

They were all in their junior year at college and were accepted as exchange students at various universities in Europe—George in Paris, Billy Wingfield at a college in Aix-en-Provence, Mack Whitaker and a friend of his by the name of Bill were in Stockholm, Sweden.

They had all agreed to meet in Paris for the Christmas holidays—but when Mack and Bill arrived in an old borrowed beat-up English Ford, they pooled their meager resources and decided to go to Bavaria for the Christmas season.

Crossing the Alps

Crossing the Alps was quite an ordeal—there were holes in the floorboard, the windshield wiper would not work, and it was snowing. This meant that the driver had to constantly stick his head outside the car to see and with his left hand wipe the snow off the windshield with a handkerchief. Then the muffler fell off and even after it quit snowing they had to keep a window open for fear of carbon monoxide seeping up through the floor.

On Christmas Eve they arrived in Munich, made inquiries and found a cheap hotel. The next morning they skipped breakfast in order to splurge for a Christmas dinner. They selected the Hofbrau haus, which is probably the most famous beer hall in the world and the prices were quite reasonable at that time. The first floor is quite large, designed primarily to drink beer—bare tables, chairs and strong buxom German waitresses who can carry five large mugs of beer in each hand. On the third floor there are small dining rooms where families eat. It is quite different—draperies, white tablecloths, napkins, silver, etc. They elected to eat here.

The waitress could not speak English or French, nor could they translate the menu from German. Sitting at the next table was a nice looking German gentleman, his wife and two daughters. Noting their plight, which I imagine they were enjoying a little bit, he gently offered his aid. They would point to an item within their price range (\$1.00 U.S.) and he would translate.

German Dinner—Roast Goose

Mack, Billy and Bill chose weiner schnitzel, which is battered veal fried. George pointed to one item, kalbskopf—it was translated "calf's head" and George said, "I'll take it."

They were famished and after what seemed like a long time the waitress came back. They were out of "calf's head," then George asked the German what was a typical German Christmas dish. He said "roasted goose," this was a fine idea but

the goose was eight marks (\$2.00 U.S.). George said no, he was budgeted for four marks only. Then his translator said, "You pay four marks and I'll pay four marks." George, of course, having conjured up roasted goose in his mind, was not slow in accepting his generosity.

Much hilarious conversation went on because the waitress brought in the weiner schnitzel for the others, but the goose was not ready and they would not allow him to taste their food, nor even give him a piece of bread. Just as his friends had finished consuming everything eatable and were coaxing the last few drops of beer from their steins, the waitress brought out on a huge plate the most beautiful piece of meat that he had ever seen. It was the breast of a roasted goose, cut off the bone, golden color, and swimming in rich brown gravy with which it had been basted. It was steaming and filled the air with savory and mouth-watering aromas. It was so pretty and smelled so good that he hesitated—but not very long—to cut it. He did not remember the trimmings, but traditionally it is dumplings and red cabbage.

Again there was much gay conversation. It was George's turn now to be selfish, but he finally broke down and gave each of them a small portion of goose. They cleaned all the platters, finished their beer and for the first time in weeks were completely satiated with good food and good beer. They were happy and well content.

All good things must come to an end however, and the day of reckoning was at hand—they called for the check. The waitress did not seem to understand, then they said "chit, chit" and "bill, bill." One pulled out his billfold and pointed to it. The waitress replied, "Fini, fini, fini." What? they asked . . . again, "fini, fini, fini," and she pointed to their translator. The kind German and his family were all smiling . . . for the first time the boys were speechless. Their benefactor arose and said: "Santa Claus has come to the Hofbrau haus!"

J. G. McDaniel, M.D.

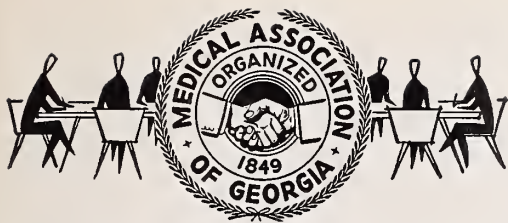
EDWIN FLOURNOY NOW HEADS FAMILY PHYSICIANS

The Georgia Academy of Family Physicians held its Silver Anniversary Annual Session October 31 through November 3 at Executive Park Motor Hotel in Atlanta. Two days of the Session were devoted to a scientific program with guest speakers on subjects from the psychiatric management of the elderly patient to pulmonary emphysema. The Board of Directors and Congress of Delegates conducted their business on the first and last days of the session.

A lively President's Banquet November 1, with entertainment by Ruby Red's band, included ceremonies in which the President's gavel was transferred from Ol-

lie O. McGahee of Jesup to Edwin E. Flournoy of Albany.

Others serving the 1973-1974 year are James C. Dis-muke of Adel, president-elect; Howard Vigrass of Columbus, vice-president; David S. Sowell of Atlanta, secretary-treasurer; A. J. Yates of Soperton, speaker of the Congress of Delegates; and Milton I. Johnson of Macon, vice-speaker. Dr. McGahee was appointed chairman of the Board of Directors and Lyle F. Herrmann was presented a plaque in appreciation of his 10 years service as secretary-treasurer.



THE ASSOCIATION

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Williams, George F. MAA—Active—Obg	2945 Stone Hogan Rd., Con., S.W. Atlanta, Georgia 30331

SOCIETIES

The **Baldwin County Medical Society** October 22 came out in support of its member, James B. Craig, M.D., superintendent of Central State Hospital, and his policies concerning the controversial open-door policy. The physicians said they were not against the policy, which has been in effect for 10 years, but the way in which it was being implemented following a recent directive from the state director of mental health.

The November 13 meeting of the **Medical Association of Atlanta**, planned by its Woman's Auxiliary, featured a western style barbeque, social hour and as guest speaker, humorist Dr. Charles W. Jarvis, a San Marco, Texas, dentist. The society's annual meeting will be held the evening of December 11 and will include an address by outgoing president Harrison L. Rogers, Jr., guest speaker Edwin J. Holman of the AMA Office of General Counsel, a memorial service and presentation of certificates of appreciation to 21 members. The slate of officers being chosen by mail ballot includes for president, Edwin C. Evans (unopposed); for vice president or president-elect, William D. Logan, Jr. and John M. McCoy; for secretary, R. Carter Davis, Jr. (unopposed). New trustees were also to be announced at the meeting.

A new slate of officers and delegates selected at the November 19 meeting of the **DeKalb County Medical Society** includes: Lawrence L. Freeman, president-elect; Lamar S. McGinnis, vice president; Stanley Aldridge, secretary-treasurer; John Heard, Stanley Aldridge, Richard Smoot and William Rawls, delegates; William Hardcastle, Roger Rowell, Clyde Rountree, Philip Christopher and James Joiner, alternate delegates; Charles McDowell and Clyde Rountree, for one year terms as junior trustees.

PERSONALS

First District

Robert DiBenedetto, Savannah internist, was appointed a Fellow in the American College of Chest Physicians at its recent annual meeting in Toronto. On November 10, Dr. DiBenedetto delivered a refresher course on "Drugs—Uses and Abuse in Inhalation Therapy" before 1,000 therapists at the meeting of the American Society of Inhalation Therapy in Atlanta.

Waynesboro physician **Charles G. Green** has been named as a Fellow of the American Academy of Family Physicians. Some 3,000 members of the Academy received the degree at the October 2 annual convention and scientific assembly in Denver, Colo.

After four years as editor of *The Bulletin of the Georgia Medical Society*, **Carl Rosengart** of Savannah has submitted his resignation so that he may devote more time to his new assignment as director of medical education at Memorial Medical Center.

Savannah's **James T. Waller**, director of internal medicine at Memorial Medical Center, has been appointed a Diplomate of the American Board of Internal Medicine.

Third District

Louis A. Hazouri, Columbus, has established the A. E. Hazouri Endowment Fund at the Emory University School of Medicine in honor of his father. Income from the endowment fund may be applied to whatever special needs the school experiences. The elder Hazouri was born and educated in Lebanon, became a minister of the Presbyterian faith, and eventually developed a Jacksonville, Fla., church which helped newly arrived Arabs learn the customs and language of the United States.

Luther H. Wolff, Columbus, is one of 54 new members of the Board of Governors of the American College of Surgeons elected at the annual clinical congress of the college in Chicago recently. Governors act as communication links between the 35,000 Fellows of the College, specialty societies, 80 chapters and headquarters staff.

Fourth District

Robert L. Bennett of Warm Springs is the author of "Conservative Management of the Wrist and Hand in Rheumatoid Arthritis: The Art of Self-Defense," published in the November issue of the *Southern Medical Journal*.

Dr. and Mrs. Harry R. Foster, Jr. of Lithonia recently traveled to New Orleans for the Southeastern Pediatric Cardiology Society meeting.

The American Academy of Family Physicians named Floyd Sanders and Horace Sawyer of Decatur as Fellows at its October 2 annual convention and scientific assembly in Denver, Colo.

Fifth District

Atlanta members **Pano A. Lamis**, **A. Hamblin Letton** and **John P. Wilson**, with Paul E. Stanton, authored an article, "Axillo-femoral and Femorofemoral Bypass Grafts: Safe Surgical Alternatives in Aortoiliac Occlusive Disease" which appeared in the November *Southern Medical Journal*.

Grady Clinkscals of Atlanta is the newly-elected vice president of the Georgia Orthopaedic Society.

J. Rhodes Haverty, at a Boston, Mass. meeting in mid-November, was selected president-elect of the American Society of Allied Health Professions. Dr. Haverty is dean of the School of Allied Health Sciences for Georgia State University.

Emory University professor of surgery (plastic), **M. J. Jurkiewicz**, served as program chairman of a two-day postgraduate course on the Injured Human Face sponsored by the American Society of Plastic and Reconstructive Surgeons. The course was presented at the Southern Medical Association's 67th Annual Scientific Meeting November 11-14 in San Antonio, Texas.

Several north Atlanta physicians have set up the non-profit Northside Medical Research and Education Institute Inc. to receive and channel gifts and contributions made toward medical research into local projects: **John M. McCoy** serves as president, **Judson L. Hawk, Jr.**, as vice president and **Milton S. Goldman** as secretary-treasurer.

Lamar B. Peacock was awarded the annual Hal M. Davison Memorial Award for the outstanding scientific presentation at the Southeastern Allergy Association meeting in October at Sea Island.

Seventh District

James Kelley of Rome will serve as 1974 president of the Georgia Orthopaedic Society, replacing the outgoing president **L. E. Dickey** of Macon. Dr. A. H. Crenshaw of The Campbell Clinic in Memphis was guest speaker at the annual meeting of the society October 11-13 at Sea Island.

Eighth District

Robert A. Pumpelly of Jesup has been appointed to fill the expired term of Dr. Y. F. Carter of Nashville on the State Board of Medical Examiners. The surgeon was graduated from the University of Kansas and practiced in Waycross before coming to Jesup 25 years ago.

Tenth District

Augusta's **James Becon** is serving as the 1974 secretary-treasurer of the Georgia Orthopaedic Society.

The October meeting of the Tenth District Medical Association saw **Thomas Averitt** elected as president. Dr. Averitt is chief of staff at McDuffie County Hospital.

Robert G. Ellison, Augusta, has been selected as a member of the Board of Governors of the American College of Surgeons. He is one of 194 governors which represent each state, each province in Canada, any country with more than 15 Fellows, 52 related surgical associations and societies, and the federal medical services.

Patricia L. Hartlage, Augusta, presented a paper to the annual Child Neurology Society meeting in Nashville, Tenn. at the end of October.

Paul R. Dyken, Medical College of Georgia, was an examiner in child neurology for the American Boards of Psychiatry and Neurology in early October in Chicago, Ill.

Augusta's **Arthur L. Humphries, Jr.** presented a paper at the First International Symposium on Organ Preservation in England.

J. Graham Smith, Augusta, has been elected chair-



Mrs. Mildred Pumpelly and Dr. Pumpelly of Jesup with Gov. Jimmy Carter at installation ceremonies for the Board of Medical Examiners.

man of the section of dermatology of the Southern Medical Association, a section which has 1,100 members. Dr. Smith is chairman of the Department of Dermatology and acting chairman of the Department of Pathology at the Medical College of Georgia.

DEATHS

Robert B. Ansley

Robert B. Ansley of Decatur, former president of the DeKalb County Medical Society, died October 26 at the age of 60.

A graduate of Emory University and Emory University School of Medicine, Dr. Ansley interned at Grady Memorial Hospital and the U.S. Marine Hospital in Massachusetts, serving in the Navy Medical Corps during World War II. He began private practice with his brother, the late Hamilton Goss Ansley, M.D. in Decatur following the war.

Dr. Ansley was a deacon of the Decatur First Presbyterian Church and was active in the Arthritis Foundation. In 1972 he was presented the Outstanding Doctor of the Year award by the Nursing Association of Georgia.

Survivors include his widow, Mrs. Vivienne Elizabeth Trice Ansley; sons, Robert B. Ansley, Jr., and Joe D. Ansley of Decatur; daughter, Mrs. Frank Allan of Macon; brothers, David Ansley of Decatur and Urquhart Ansley of St. Simons Island.

Crawford Fannin Barnett

Crawford Fannin Barnett, 67, an Atlanta internist and gastroenterologist since 1933, died November 3.

Dr. Barnett was on the staffs of Crawford W. Long, Georgia Baptist, Piedmont, Grady Memorial and Emory University hospitals. He was a founding member of the American Society of Gastro-intestinal Endoscopy and a member of the Hunterian Medical Society of London, England. Dr. Barnett was a member of the American Association of the History of Medicine, was a founder and officer of the Georgia Amateur Athletic Association and served as a member of the Metropolitan Foundation of Atlanta.

Dr. Barnett's B.S. and M.D. degrees were received

ASSOCIATION / Continued

from Emory University. Postgraduate work was pursued at McGill and Harvard universities.

Survivors include his widow, the former Penelope Hollinshead Brown; daughters, Penelope Barnett, Mrs. Lawrence T. O'Connor and Mrs. Paul C. Pritchard; son, Dr. Crawford F. Barnett, Jr., all of Atlanta.

Virgil W. Osborne

Retired Atlanta physician, Virgil W. Osborne died November 1 at the age of 86.

Dr. Osborne was a native of Brevard, N.C. where he

attended Brevard Institute, the University of North Carolina and Davidson College before receiving his M.D. degree from Atlanta Medical College in 1916.

He served in the Army during World War I and practiced in McRae, Stone Mountain and, in 1926, in Fulton County. In Stone Mountain, Dr. Osborne taught school at the University School for Boys and served on the city council. He was a member of the Druid Hills Baptist church, Joseph C. Greenfield Masonic Lodge and Ansley Golf Club.

Survivors include two daughters, Mrs. Jeanne O. Gibbs and Mrs. J. W. DuBose of Decatur; three grandchildren.

GEORGIANS SERVE AS DELEGATES, MODERATORS AND SPEAKERS FOR AMERICAN HEART ASSOCIATION ANNUAL MEETING

A number of Georgia physicians, among them many MAG members, participated in the 1973 Scientific Session of the American Heart Association in Atlantic City, N.J., November 8-11 and the Annual Session which followed it. The program attracted more than 10,000 physicians, nurses, scientists and business and civic leaders.

Serving as state affiliate representatives to review current programs and discuss future directions were Hilliard A. Bowen, M.D., Charles R. Hatcher, Jr., M.D., Haywood N. Hill, M.D., Mr. George E. Smith and Nanette K. Wenger, M.D. of Atlanta, C. Dan Cabaniss, M.D. of Columbus, Robert G. Ellison, M.D. of Augusta and Curtis G. Hames, M.D. of Claxton.

Two of the delegates and four other Georgia Heart Association volunteers participated in panel discussions November 11 to examine management, program and fund raising policies: J. Gordon Barrow, M.D., J. Willis Hurst, M.D., Rease Inge, Joseph A. Wilber, M.D., Mr. Smith and Dr. Wenger, all of Atlanta.

Dr. Hurst, immediate AHA past president, was a chairman for the Clinical Sessions and moderator for a panel discussion on "How to Examine the Heart and Circulation." Dr. Wenger chaired a panel on "Risk Factors and Screening."

Other MAG members participating in the Scientific Sessions include Robert Schlant, chairman for a session on Clinical Research; P. N. Symbas, who presented a paper on the "Delayed Sequence of Penetrating Cardi-

ac Wounds"; Nancy C. Flowers, who chaired a session on electrophysiology and presented a paper on "His Bundle and Bundle-Branch Recordings from the Body Surface."

Georgians serving on AHA Committees this year are Dr. Barrow, chairman of the Medical Committee on Community Programs; Elbert P. Tuttle, Jr., M.D., Committee on Scientific Sessions and the Council for High Blood Pressure Research; and Dr. Wenger, chairman of the Medical Committee on Rehabilitation and member of the Committee on Community Programs.

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